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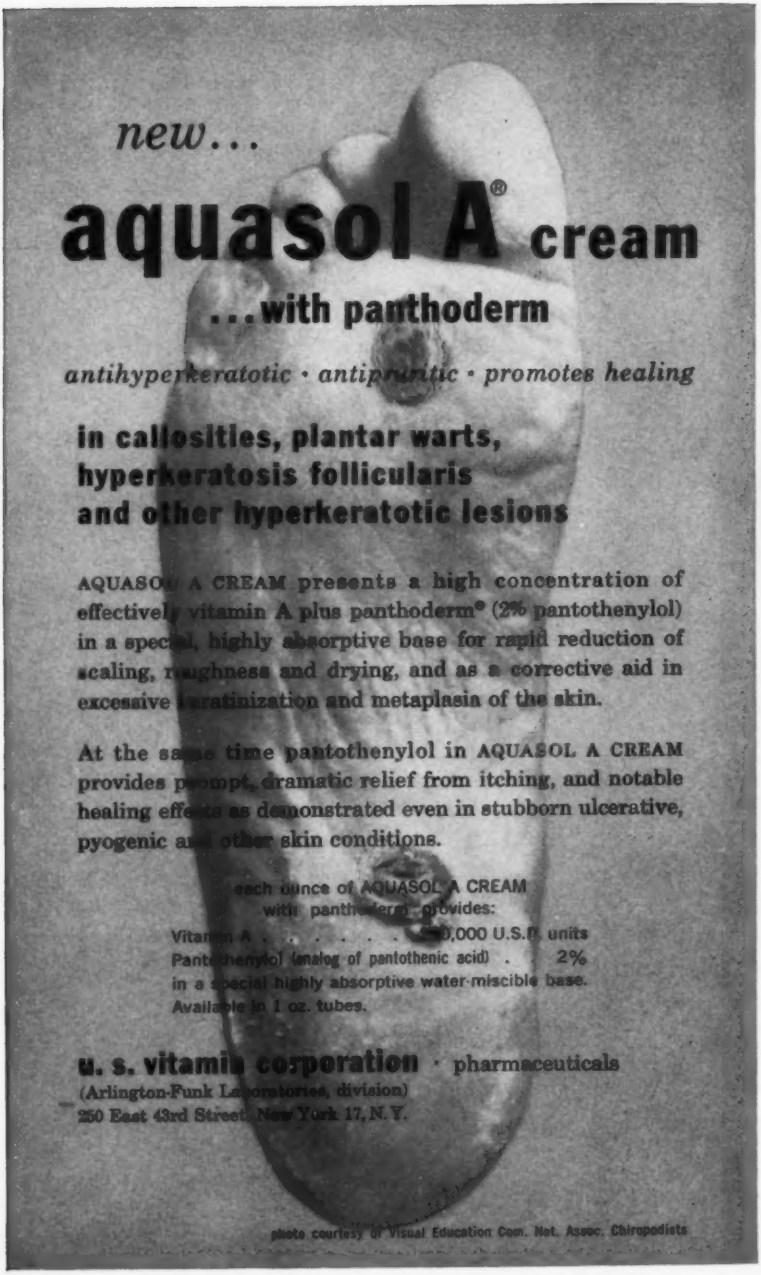
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Subscription is included in the annual membership dues of the National Asosciation of Chiropodists. The subscription rate for non-members is $10.00 a year in advance. Single copies $1.00 each. Remittance should be made payable to the National Association of Chiropodists.

Notice of change of address should be received six weeks before the change is to become effective. Old and new address must be given.

The *Journal of the National Association of Chiropodists* is published monthly and copyrighted in 1956, by the National Association of Chiropodists.

Entered as second class matter at the P. O. at Boston, Mass., March 27, 1934, under the act of March 3, 1879. Publication office, 375 Broadway, Boston, and Editorial-Executive offices 3301 16th St., N.W., Washington 10, D. C.

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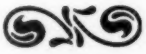

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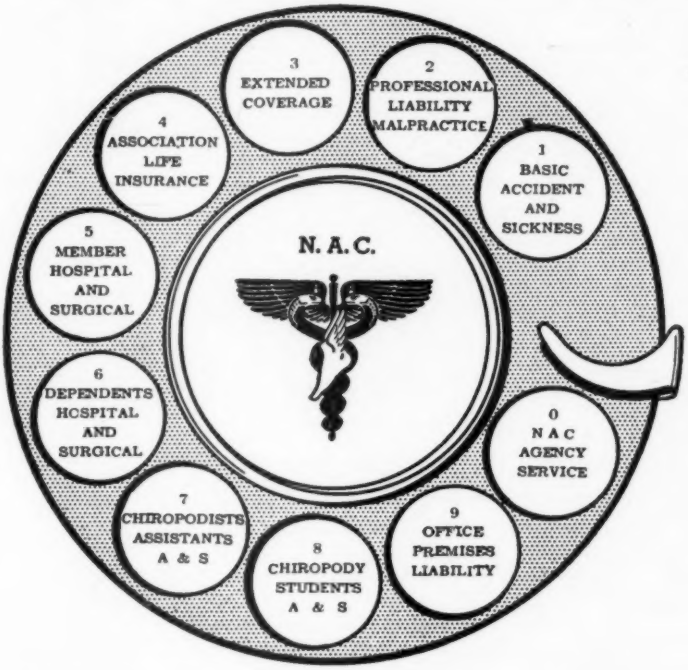
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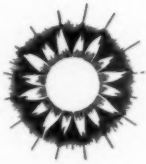

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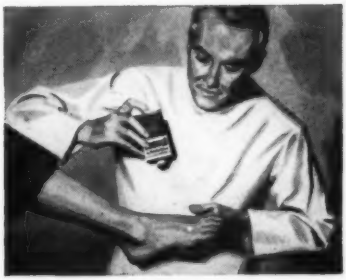

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THE OFFICIAL PUBLICATION OF THE PROFESSION

VOLUME 46 AUGUST, 1956 NUMBER 8

PROBLEMS OF LOCOMOTION AND THEIR TREATMENT IN THE BRAIN INJURED CHILD AND ADULT

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Foreword

THE OBJECTIVES of this paper are to state briefly some of the facts that are known about cerebral palsy purely on an informative basis rather than as a scientific treatise, and to cover with some degree of precision most of the problems that the chiropodist can cope with successfully, both in clinical and private practice. Because of the fact that the author believes in the thesis of treating cerebral palsy children in infancy, if possible, most of this paper will be devoted to chiropodical care during the formative years. The adult problem will be covered to a lesser degree. The work as presented in this paper covers a period of the past ten years—from 1946 to 1956, and the clinical phase of the work alone covers a three year period during which time I was associated with the Cerebral Palsy Rehabilitation Center of Mercy Hospital in Chicago. I am still associated with the Center as attending chiropodist. My total number of cerebral palsy patients in private practice during this ten year period totaled 41. At this writing I have attended more than 90 patients at the clinic for rehabilitation problems associated with locomotion.

Because the chiropodical problems of the brain injured child and adult are primarily related to locomotion, I shall offer no still pictures in evidence of my thesis, but instead I offer a 16 mm. moving picture film as part of this report.

Motion Picture Sequence

This film† will depict the use of "skate" therapy on three patients taken at random from the progress chart listed at the close of this article. These patients are listed in the chart as numbers 21, 2, and 10, as seen in consecutive order on the film study.

Patient number 21 was first seen by me two years ago when she was four and one-half years old. She was the oldest of two children, her sister being one year old at the time and normal in all respects. This patient was born blind and her problem was diagnosed as spastic quadriplegia. At the time I first

*First Award, The Wm. J. Stickel Annual Awards for Research in Chiropody for 1956.
†A 16 mm. moving picture film accompanied this paper, and was shown at the 1956 Annual Meeting.

examined her she could stand by herself for a very short period of time but could not walk without being held by the hand. She was very apprehensive and became alarmed at the slightest provocation. She held her feet in a very marked pigeon toed position at all times and her limbs were always internally rotated. Upon examination I found that her limbs could be rotated externally about 40 degrees and internally 150 degrees.

The "skates" were constructed to maintain an external rotation of both feet and limbs at 30 degrees with a maximum external rotation of 90 degrees. The mother was instructed to keep the appliances on the child day and night and to remove them only when the child was bathed or dressed. The films show sequences at the start of the therapy with the "skates," two months later, six months after that, and one year after therapy was started. After wearing the skates for eight months the child was allowed to go without them all day long and she wore them as a night splint. At the present time the child is no longer wearing the skates and all the gains have been maintained.

In this patient as well as some others listed in the chart, we found that when the limbs were derotated and the feet were brought back into normal contact with the walking surface, a weakness in the longitudinal arch structures became evident. In each such instance I used supportive measures after the initial therapy had been completed. My experience proved that balance therapy with the use of balance inlays provided adequate results. Two months ago this patient accompanied her mother on a shopping trip and visited me at my office the same day. Not only was her physical condition greatly improved, but her apprehensiveness and her entire outlook have benefited to a marked degree.

Patient number 2 was three years and three months old when I first examined her one year ago. She was also diagnosed as a spastic quadriplegic and she walked on her toes bilaterally with an inverted, or pigeon toed gait. The first sequence of the film shows this gait problem with and without her shoes. The left foot showed all signs of developing talipes equino varus tendencies. This child, as well as patient number 21, had received exercises to stretch the posterior group of leg muscles for some time without positive results.

The second sequence was taken at the Mercy Hospital Rehabilitation Center two months after the "skates" were applied. She also had been wearing the "skates" 24 hours a day and at the end of the two-month period her total gait was almost normal. After these films were taken the mother decided of her own accord to remove the "skates" during the period of warm weather and when the child was seen three months later some of the original symptoms had returned. The mother was instructed to keep them on full time for an additional three months before the child was allowed to remove the "skates" during the daytime. This follow-up program maintained full correction and the child is doing very well at this writing.

Patient number 10 was a fully grown young adult, 17 years old, when she was first examined by the writer. She was attending high school for crippled children. A diagnosis of "Athetoid" was made for this patient even though most of her actions were quite similar to those of a spastic quadriplegic. Her muscular structures were all tight and the first film sequence will

show that she exhibited a considerable amount of incoordinate motions. Her feet and legs rotated inward and she had developed a decided cross-legged or scissored gait. Both of her heels were elevated from the floor as she walked on her toes most of the time. Her standing balance was also awkward and unsteady.

In October 1955 we decided to use "skate" therapy on her because nothing further could be done for her condition. She was asked to wear them as much as possible and she cooperated very well. At school she removed them only when she had to leave the class to go home. On weekends she wore them full time. The second film sequence shows the results that were achieved with "skate" therapy in this young adult after ten weeks.

Since these films do not as yet have titles I hope that the viewers will bear with me. Sometime in the future I will include such titles.

An Introduction to the Problem of Cerebral Palsy

Cerebral palsy may be defined as a disease seen at birth or in early infancy and is characterized by a disturbance of voluntary motor function. The essential pathology is a destruction of congenital absence of neurons in the cerebellum or cerebrum. Cerebral palsy is to be suspected if the newborn infant does not breathe well, fails to nurse, remains bluish in color, has convulsions, or shows marked weakness or tightness of the muscles. The most common cause of the destruction of the brain cells is thought to be hemorrhage into the brain prior to or immediately following birth. Anoxia of the brain in utero is also thought to be responsible for much of the brain damage.

In many instances nothing unusual is noticed about the child at birth until it becomes obvious that the child cannot hold its head, sit up, stand, or walk in the same time sequence as that carried out by normal children. The child is unable to relax his muscles normally, and his movements are jerking, labored and inaccurately executed. The area of the brain damage in spasticity lies near the mental area and sufficient destruction may occur there also to produce varying degrees of mental retardation. However, retardation can also be present due to the physical handicap, as a result of which the child finds it difficult to express himself.

Numerically the problem of cerebral palsy is significant for it is estimated that there are more than 400,000 in the United States. Although the subject of cerebral palsy has been neglected in our medical literature, we are beginning to lift the curtain of confusion that has covered this disease for many years.

Classification

Most authorities now agree that cerebral palsy may be classified according to the anatomic site of the brain lesion, the clinical picture, the impairment of the extremities, the degree of tonicity, the severity of the involvement and the etiology.

The site of the brain involved covers three general categories:

1. Pyramidal tract problems are most often true spastics and the clinical syndromes are thought to be due to the removal of the inhibitory effects of the pyramidal tracts.

2. Extrapyramidal tract problems are primarily associated with athetosis, choreas, tremors, ballismus, dystonias, and rigidities.

3. Cerebellum problems are most often associated with ataxics and atonias.

The most accepted clinical classification divides all cerebral palsy patients into five primary groups: spastics, athetoids, tremors, ataxics and rigidities.

1. *Spastic Type.* In this type the pathology to the brain affects the muscle directly and the "stretch reflex" is a special characteristic which distinguishes this type. When a normal muscle contracts its antagonist must relax, allowing the muscle tone to become lowered enough to allow the desired motion to be carried out. This phenomenon is known as Sherrington's Law of Reciprocal Innervation. In contrast, the spastic muscle is hyperirritable and reacts to any stimulus by contracting not only the agonist, but the antagonist as well.

Another diagnostic feature of the spastic is the "cerebral Zero" or 0° C. muscle. These muscles have no power to carry out function and they are not generally found in the other forms of cerebral palsy. To test for such a muscle the muscle should be put into the contracted position by the operator and if the patient is unable to hold it in that position voluntarily it must be recorded as 0° C.

The equinus limp is another frequent finding. This finding is not due to the weakness of the dorsiflexors but to the simultaneous contraction of the more powerful plantarflexors. This is particularly true of the hemiplegic spastic who can usually walk, but the affected leg will drag and is not too useful.

The scissors gait or cross-legged progression gait is associated most often with the paraplegic and quadriplegic types. This gait is characterized by a disabling adduction of the hips due to the greater strength of the adductor groups of muscles. When this persists other characteristic deformities develop as time goes on. The hips may become flexed, adducted and internally rotated. The knees are flexed and the feet assume an equinus or equinovarus position.

2. *Athetoid Type.* Athetosis has been described as "a condition in muscles which brings about contractions without voluntary direction, and without voluntary control." The athetosis involves the involuntary motions only and the voluntary motions are not affected. The athetoid who makes no effort to stop these involuntary motions is known as a nontension athetoid while the athetoid who voluntarily tenses to stop these involuntary motions is called a tension athetoid.

In the athetoid the damage in the brain is to the basal ganglia which control the joints of the body. The ganglia act as a filter and sort out desired motions. When these are damaged the sorting function is interfered with and all impulses pass through causing involuntary motion in all parts of the body. The ability to control motion at will is lost. Feeble mindedness, if found, has no direct relationship to the athetoid condition.

Generally speaking the athetoid must be slowed down, while the spastic is a slow-moving child and must be speeded up.

3. *Tremor Type.* This is a type related to the athetoid in which the motion not only returns to the neutral stage but goes beyond, into overflexion and overextension. Intentional tremors occur during a voluntary attempt to move at will. Unintentional tremors are more or less constant and occur at all times.

4. *Ataxic Type.* Ataxia is caused by damage to the cerebellum--the brain center controlling balance. The kinesthetic sense, which is the ability to know the position of joints in relation to other parts of the body, is lost. Control of direc-

tion of force of motion is difficult once voluntary action is begun. These patients must be treated by training other motor centers to take over the work of the impaired area.

5. *Rigid Type.* This type is characterized by a stiffness in the muscles of the arms and legs with no involuntary motions or stretch reflex present. Muscles respond slowly and with difficulty when a stimulus is applied. Rigidity appears to be caused by a diffuse lesion of the brain and occurs often after a convulsive seizure. The muscles may be rigid in the flexed and extended positions.

Cerebral palsy may be further classified on the basis of the topographical distribution of the involvement. The incidence of the impairment of the extremities has been listed as follows for the most commonly used terms:

1. Quadriplegia—
   all four extremities—60%
2. Hemiplegia—
   arm and leg on one side—20%
3. Monoplegia—
   single extremity involved—10%
4. Paraplegia—
   both legs involved—10%

It is thought that patients with quadriplegia who have most of the involvement in the legs are usually spastics and those in whom the arms are primarily involved are athetoids.

The problem in hemiplegics affects one half of the body. While it is presumed that all hemiplegics are spastics, pure hemiplegic athetoids have been reported. Some hemiplegics present an atrophy of the affected arm and leg resulting in a shortage of one or both. These cannot be explained on a disuse basis and must be presumed to be congenital in origin. There may also be a sensory involvement on the affected side. Proprioception, two-point discrimination and form perception may be affected.

Some authorities believe monoplegia to be relatively rare, but when it does occur it is believed to be spastic in nature.

Paraplegics are thought to be of the spastic variety in almost all instances.

The change in muscle tone is also one of the characteristic findings in the cerebral palsy patient. Physiologically, the state of the muscle can be classified as:

1. Having normal tone—isotonic
2. Having increased tone—hypertonic
3. Having decreased tone – hypotonic or atonic.

All types of cerebral palsy patients may present these varied muscle tones to a more or less marked degree and that must be taken into consideration when making the diagnosis, prognosis and deciding on the treatment.

We have already stated that cerebral palsy patients can also be classified according to the degree of involvement present. This classification can fall into the three grades of mild, moderate and severe and its importance is most apparent to those who treat such patients clinically. The significance of this classification will become apparent in this thesis.

The final classification that can be of considerable value to the total analysis of the subject is the classification according to etiology. A division of this classification into prenatal, natal and postnatal factors must be apparent.

A. Prenatal—may be due to genetic defects or to injuries acquired in utero.

1. Hereditary—genetically transmitted.

a. Static—symptoms are present at birth and do not progress. Examples are, familial tremors, hered-

itary athetosis and familial spastic paraplegia.

b. Progressive—symptoms may or may not be present at birth but may appear in later years. These are progressive and generally fatal —Tay-Sachs disease, demyelinating disease and tuberous sclerosis.

2. Acquired in Utero—
a. Prenatal infection
b. Prenatal anoxia
c. Prenatal cerebral hemorrhage
d. Rh factor
e. Metabolic disturbance
f. Gonadal irradiation.

B. Natal factors—Those factors operating during the period of delivery to the birth of the child.

1. Anoxia
2. Cerebral hemorrhage and contusions

C. Postnatal factors—Factors operating after birth.

1. Trauma
2. Infections of the Central Nervous System
3. Toxic causes including chemical poisoning.
4. Vascular accidents
5. Anoxia
6. Neoplastic or late developmental defects.

The General Foot Problem

All cerebral palsy children require constant proper pediatric care and they all respond in some measure to the various methods employed by physical medicine. While foot problems are only a part of the total difficulties that must be dealt with in the care of these children, these problems present a challenge to the medical team and it is in this category that the chiropodist can be a distinct asset to that team endeavor.

When we consider cerebral palsy children from the chiropody point of view we can divide all patients into three primary categories: those who have so little functional possibilities that they may never be able to bear their own body weight in the upright position; those who will walk with some degree of marked handicap at some time or other before puberty, and those who can walk with a mild degree of handicap at an early age.

It is logical to assume that we cannot be of much help to the first group, most of whom may become institutionalized sooner or later. The other two groups can use our services to advantage. In these two groups we must direct our attention to the task of preventing deformity where there is any indication that it may develop, overcoming deformity where it already exists, and adding to the general comfort and well-being of the patient by means of general prophylactic care of the feet.

Working with cerebral palsy children requires many years of attention and supervision of each individual case. Only then can we be assured that these children will be able to stand and walk well enough to take their places in our community as useful citizens. Such a program can be carried out best by a complete team effort of medical men and all affiliated medical services.

Skate Therapy

It has been ten years since the author treated his first very young cerebral palsy patient for what was essentially a problem affecting the gait of the child. For several years I had been working with a mechanical device attached to surgical shoes which had produced very favorable results in children with talipes equino varus, talipes equinovalgus, talipes varus and calcaneo valgus. As a result of this work I saw many young patients with problems other than those listed

and it was inevitable that I should see some cerebral palsy children among them.

I must admit now that my knowledge of the cerebral child was very limited indeed and I found next to no literature available on the subject. My ignorance ten years ago was shared by most men in the allied medical fields so I found myself in very poor company. Within a period of five years after the first patient, I saw more than 25 patients with a variety of problems associated with cerebral palsy, and as the result of some trial and error therapy I arrived at some basic findings about the treatment that I could use with some success.

In 1949 I gave a short talk on the subject of "skate" therapy. In that talk I stated the following: "The cerebral palsy problem came to us slowly at first, but in the past few years, with the entire country more and more aware of this childhood malady, we are compelled to turn our attention to cerebrals of all types. The problems of aiding the cerebral child to walk is to some extent our problem. There was a time when the authorities on cerebral palsy paid little attention to the walking problem but it is realized today that the cerebral child who can walk best will improve more rapidly in all other aspects also."

"With these patients the Brachman 'skates' are employed as a device to encourage a physiologically correct neuromuscular training program. Since the normal pathways from the brain to the periphery are destroyed or impaired, a fairly good substitute pathway can be set up with constant usage of the 'skates' and other encouragement. The appliances prevent the patient from performing any exaggerated movements and control the gait to a fairly normal range of movement.

"The use of the 'skates' on cerebrals has been most gratifying because of the results which have been obtained in a number of patients. We have applied these 'skates' to patients from three to five years of age who have never been able to stand alone or take a step unaided and within six months to one year these children were able to stand unaided and take steps unaided. This aspect of the work has been most encouraging and we hope that the use of the 'skates' will become more widespread than ever in the care of cerebral palsy patients."

The term "skates" in this thesis requires some explanation and description. Originally these devices were called the Brachman Talipes Splints or Reciprocal Ambulatory Skid Plates. They consist of two sliding metal bars which are sandwiched in between two aluminum plates attached firmly to each shoe. The device is so constructed that the patient is allowed to use his feet only in a pre-determined range of motion, usually an overcorrected range, as prescribed by the doctor.

The "skates" are most efficient when they are attached to a surgical type shoe because such shoes are constructed well enough to stand up under the wear and tear that they receive. Furthermore, these shoes have open lacings to the end of the toes and it is not too difficult to place a contorted foot into the shoe. There are five basic types of "skates" designed to care for five specific foot and leg patterns associated with unilateral and bilateral problems. These five factors multiplied by the many individual factors that must be included with each prescription have made it necessary from the very start to construct each pair on an individual basis.

Chart Relating to "Skate" Therapy for Twenty-One Cases Selected from Clinic Files

Patient Number	Age	Sex	Length of Time Skates Were Used—in Months	Improvement of Balance or Walking	Improvement of Limb Rotation	Improvement of Equinus Position	Diagnosis—Type of Cerebral Palsy
1	4.6 mo.	M	9	Good	Good	Excellent	Spastic Quad.
2	4	F	12	Good	Excellent	Excellent	Spastic Quad.
3	4	F	18	Good	Good	Excellent	Spastic Hemi.
4	10	M	6	Good	Good	Good	Spastic Quad.
5	6	F	7	Good	Good	Excellent	Spastic Hemi.
6	7	M	5	Fair	Good	Good	Spastic Quad.
7	3	F	3	Good	Good	No Problem	Mild Dipleg.
8	4	F	6	Good	Excellent	Fair	Spastic Para.
9	5	M	4	Good	Good	Fair	Spastic Para.
10	17	F	5	Good	Good	Good	Athetoid
11	5	M	5	Good	Good	Good	Athetoid
12	5	F	9	Fair	Good	Fair	Spastic Dipl.
13	3	M	12	Excellent	Excellent	Excellent	Spastic Quad.
14	7	F	10	Fair	Excellent	Good	Spastic Quad.
15	7	M	11	Good	Good	Excellent	Spastic Quad.
16	11	M	11	Good	Good	Good	Spastic Dipl.
17	4	M	10	Good	Good	Good	Spastic Dipl.
18	15	F	6	Poor	Fair	Fair	Spastic Dipl.
19	4	F	8	Excellent	Excellent	Excellent	Spastic Hemi.
20	7	M	8	Excellent	Excellent	Excellent	Spastic Hemi.
21	4.6 mo.	F	18	Excellent	Excellent	Good	Spastic Dipl.

Comments: Nos. 3, 13, 19, 20 and 21 no longer are required to wear the "skates" and are maintaining the correction they have achieved for periods of 6 to 18 months since removal.

Key to Improvement:
Poor—0 to 10 percent Fair—10 to 30 percent Good—30 to 60 percent Excellent—60 to 90 percent

Thus, each pair of "skates" is made and attached to each shoe by hand as ordered by the doctor, and they are so designed that they cannot be changed unless they are returned to the laboratory under the order of the doctor. When I first designed these "skates" I found that if the parents of these patients were amateur mechanics they would reset the angle of correction at their own discretion and I was compelled to freeze the amount of correction in self-defense.

In using the "skates" the patient is taught how to move them. The doctor instructs the parents in the best technique designed to teach the child. The amount of activity indulged in by the patient is prescribed by the doctor, because it is obviously necessary to limit the activity to a few minutes in each hour if the structures are very weak and not accustomed to bearing weight. This time element can be increased gradually from week to week.

Basically the "skates" allow the patient to perform most of the movements associated with locomotion, thus using principles of mechanics that are physiologically correct. More specifically, the "skates" may be said to carry out the following physiological principles:

1. In normal walking we use one foot at a time and the young child obtains no more than 8 to 10 square inches of base support from each foot. When using the "skates" both feet are always in contact with the floor and this base area of support includes the entire parallelogram of not less than 100 square inches. This factor alone induces the patient to balance himself once he finds it easier to do so and loses his fear of falling.

2. All undesirable movements are restricted and new and more desirable habit patterns affecting the neuromuscular pathways are developed. By so doing we may be blocking off the early patterns established by the brain pathology present and we may be using some of the more normal associated pathways for our locomotion. While this is now just conjecture, it may be established by future investigation. The fact that these changes occur is of major interest to us at the present time. Because these "skates" are worn day and night from the very start, the training program is uninterrupted and the new pattern has an excellent chance to become established on a more or less permanent basis. Of course, all of these factors also depend on the cooperation offered by the parents of the children we are treating.

3. All tightened and contracted structures are stretched with every movement that is made while the "skates" are worn.

An Approach to Treatment

To facilitate this broad problem of the approach to the foot care of the cerebral palsy child and young adult, we will describe what can best be done for these patients on the basis of the severity of the involvement. Earlier in this paper we have classified these patients into three groups: mild, moderate and severe.

Since the mild group includes all those patients who are able to walk, use their arms and speak fairly well, our contact with them, clinically or as private patients, is rather limited. Their foot problems and gait problems appear to be no greater than those of our average citizens and it is only when they become injudicious in their activities that they require attention.

In most instances their problems are associated with early fatigue, limitation of range of motion and

some loss of proprioceptive and kinesthetic sense. A close neurological and muscular examination together with a good case history will aid considerably in making the diagnosis. In treating such patients it must always be remembered that we cannot replace what was never there to begin with, just as in the more severe types. Our attention, therefore, must be directed toward palliative treatment plus giving them some mechanical advantages through the use of mechanical therapy.

In the severe type, where there is total involvement and the patient is either bedridden or confined to a wheel chair and where the prognosis is very poor, the amount of good that we can do is negligible. However, it is very difficult to make a totally morbid prognosis for the very young child because there are so many factors that may change the situation after a few years' time. During the four years that I have been associated with the Mercy Clinic I have seen several children make some progress who appeared almost hopeless in infancy and I have also seen other children deteriorate as they became older.

Thus, as foot doctors, our basic approach to all infants and very young cerebrals must be hopeful. Where there are signs of impending foot and leg deformity we must try to prevent them and where they already exist when we first see these children we must correct them so that as the child gets older and the time comes for the first phase of locomotion to be developed, there will be no major deformity as a factor to be considered.

It is in the third, or moderate group, that we can do our very best work. This is the group where the involvement is always severe enough to handicap the patient in locomotion. Out of an active patient list of about 250 attending the clinic I have more than 90 directed to my care for special foot and gait problems. Of these patients 41 either are wearing Reciprocal Skates or have worn them during the past three years. The remaining 49 patients are receiving mechanical aids that range from shoe therapy to balance inlays, shortage devices and metal therapy.

Because the care and treatment of a cerebral palsy child require the services of a medical team, it is essential that the chiropodist who desires to take his place on this team sit in on a sufficient number of examinations and conferences so that he will understand and appreciate every phase of the problem. At the Mercy Clinic I have access to all of the examinations and conferences in progress together with the medical charts pertaining to each patient. Thus I am fully aware and conscious of the total problem of each patient that I shall see. In most instances, that also includes the family problems and the psychological problems which are almost always present.

I have found that the most important of all clinical conferences I have attended were in conjunction with the examinations conducted by the physiatrists. Their basic approach to the problems of rehabilitation is so closely allied to our own work that we can work in harmony every step of the way. I have made an effort to be present at the physical examination of each new patient by the physiatrist. At the completion of the examination I am usually invited to take over and re-examine the patient from a chiropodical point of view. In each instance that examination includes reflexes, range of motion, muscular function and an evaluation of basic walking patterns now existing or likely to become activated. At this

point I confer with the physiatrist on the best therapeutic approach for locomotion or any other foot problem that may be present.

It must be apparent by now that our approach to these various problems must have become somewhat standardized over a period of four years and to some extent that is quite true. The cerebral palsy patient is no different in that respect than any other patient. Certain problems fall into categories almost automatically with only the degree of severity serving as the greatest variant. Here again we would do best to follow a classification in our discussion and the topographical pattern plus the clinical symptoms will become our best guide.

The spastic hemiplegics are an easily distinguishable group even at a very early age. The mechanics of one entire side of the body are affected and the child fails to use the affected hand but prefers to use the hand on the unaffected side. At a very early age of about six months the affected foot may show signs of an impending talipes equino varus position. Furthermore, all reflexes are exaggerated on the affected side and the encephalogram will verify the damage done to only half of the affected brain area.

If these children were not treated and left to their own devices as they undoubtedly were years ago, they would grow up with very little or limited use of the extremities on the affected side. In most instances the hand would be useless and the foot would assume a marked talipes equino varus position ending up in a complete deformity with fixation of all the articular structures. In many instances there is an associated knee and hip deformity which may be present very early or show up later as a factor associated with improper function. Because of the marked malfunction that exists there is always an associated shortage syndrome of the limb on the affected side. All of these factors require consideration in a planned course of treatment.

Of all the cerebral palsy patients the spastic quadriplegics probably make up the largest group. We have already stated that the very severe cases are not within the scope of the chiropodist's help once it has been established that the patient is nonambulatory. On the other hand, the more moderate cases can use our services as long as they live and with considerable benefit.

The quadriplegic spastic has no single peculiarity of gait. He may begin to show signs of ambulation at an early age and often learns how to walk before two to three years of age, and again he may not take his first steps until the seventh year or later. The ability of this patient to walk is always dependent upon his ability to control his head and trunk muscles first. It is axiomatic that no spastic can walk before he learns to control his upper extremity.

When that control has been achieved, often after a great deal of effort on the part of the medical team and the family, then the patient is ready to walk, or at least make an effort to learn. What are the problems associated with the extremities of the spastic quadriplegic that may require attention? First and foremost there is always the inequality of the muscles due to the innervational overload affecting some of the muscles while others may actually register zero. The stretch reflex is always present with the true cerebral spastic. Whereas in a normal muscle a response to a stimulus will bring with it a contraction of the stimulated muscle and a relaxation of the antagonist, the spastic muscle will produce a contraction of both the

agonist and the antagonist resulting in a sort of stalemate of activity. In other words, the antagonist opposes the normal action of the agonist.

With this lack of coordination going on between certain muscles and muscle groups one can readily visualize how difficult it becomes to initiate normal movement. Breaking up this stretch reflex pattern is a very difficult and tedious procedure and some muscles never respond favorably to any form of therapy used as a routine procedure. Of all therapies the one universally used at the present time includes all forms of massage and manipulation, often preceded by warm tub soaks or other forms of heat to induce some relaxation of the soft structures.

Dr. Karel Bobath and his wife, members of a British medical team, have had some success with a form of restraint therapy followed by rehabilitation exercises. By inhibiting the unorthodox movements through restraint they weaken the muscles to the point where they cannot resist passive normal motions. By this method they hope to give the patients an opportunity to become acquainted with the normal movements until they can carry them out of their own accord. Dr. Bobath's method of therapy is being used at a few clinic centers in the United States and the results are now being watched with a great deal of interest. The reports emanating from these centers are optimistic but not enough information has been gathered as yet to make any positive statements concerning the merit of this method of treatment.

The spastic patient presents a large variety of foot problems and associated knee and hip problems from early infancy. There may be a unilateral or a bilateral talipes equino varus, talipes equino valgus, talipes varus, talipes valgus, calcaneo valgus, or talipes calcaneous. There may also be a talipes varus problem of one foot and a talipes valgus problem of the opposite foot. In other words, any possible combination of deformity problems may exist in the same patient. Associated with such foot problems we may also find hyperflexion or hyperextension of one or both knees, coxa vara or coxa valga of one or both hips, and a marked inward or outward rotation deformity of one or both limbs. It is also possible for one limb to be outward rotated with the opposite limb having a severe inward rotation problem.

As a general rule the digits of the toes are almost always involved with the primary problem associated with the hallux. The first digit usually shows the effects of a weakened extensor digitorum longus and a spastic flexor hallucis longus. With all of these problems so often affecting the spastic patient it is little wonder that they never develop normal articulations as they grow older. Neither do they ever achieve normal balance and a coordinate walking pattern.

Finally, as these patients grow older, those who do get around develop pressure areas that need constant attention by the chiropodist in order to give the utmost comfort and stability. With all of the neurological problems already attendant with their spasticity, any other painful areas that are present on their feet may become an insurmountable factor in their effort to remain ambulatory. These patients require all of the patience and skills at our command to give them palliative relief by means of our surgigal skills, mechanical aids and shoe therapy.

(Continued on Page 541)

A NEW INSOLE MATERIAL FOR SHOES*

GEORGE O. SHECTER, D.S.C.
Los Angeles, Calif.

This is the first of a series of articles reporting on a five-year research program into shoes, shoe design, shoe fit, last shapes and shoe materials.

The shoe industry in the U.S.A. produced over 575 million pairs of shoes in 1955. In value this exceeded 2 billion dollars. Any industry of such magnitude should be engaged in extensive research to find and develop new materials, new designs and new lasts. The need for research and better things has been proven beyond any doubt. Organized research in the shoe industry and research into the problems of shoes and feet is seriously lacking. The few and admirable exceptions merely emphasize the need for more and widespread research.

Every survey undertaken by the Army, (in the U.S.A. and Canada), the National Foot Health Council and others, has revealed a painfully large segment of our population suffering with some form of foot and shoe problem.

This paper reports on the problems of the shoe insole and its effect on the foot.

The shoe insole has a considerable impact on foot function and foot comfort and is therefore of major interest to foot specialists, shoe manufacturers and consumers. A poor insole causes general discomfort and often gives rise to specific conditions, such as plantar neuroma, calluses, dermatitis, etc.

The literature, both medical and technical, is very limited on the subject of insoles. It was necessary to obtain the specifications for an ideal insole through personal correspondence with medical and technical experts (foot specialists, dermatologists, shoe manufacturers, chemists, etc.) in the U.S.A. and other countries.

What Are the Requirements for an Ideal Insole

1. It should allow the foot to function normally during standing and walking.
2. It should aid the normal motion of the foot.
3. It should conform to the contours of the foot.
4. It should support the foot.
5. It should not be rigid or hard.
6. It should not interfere with the normal physiology of the foot (perspiration, etc.).
7. It should not interfere with the heat exchange of the foot.

As one correspondent (Stern) put it: "The shoe should capture the sandy beach to walk on." To these ideal requirements must be added the needs of the manufacturer; ease of handling, cost, durability, style and the parallel problems of the filler material. The filler, the material between insole and sole, has considerable influence on the wearing qualities of the shoe. A filler which breaks down quickly produces cracks in even the best insole, and more importantly, allows an early breakdown of the insole surface which causes many foot problems. A superior filler which does not bunch, remains flexible and does not interfere with foot mechanics, is marketed in Great Britain (Besto-Flexite) but has not yet been distributed in the U.S.A. Each type of manufacture

*This program was made possible through the cooperation of Larry Hirsch (Hirsch Laboratories, Los Angeles, Calif.)

demands its own specifications: The Goodyear Welt shoe demands an entirely different insole from the Compo shoe or the Slip-lasted shoe.

Comfort and Sensation

A major consideration about insoles, concerns the feel of the insole material in contact with the foot.

The foot is a major organ of sensory, reception and perception, The foot transmits to the nervous system, heat and cold, shock and vibrations. The tactile receptors of the foot are almost as sensitive as those in the hand. Any material which feels foreign to the skin of the foot cannot be comfortable.

This feel is most important relative to the surfaces of the insole, its temperature, flexibility and ability to conform to the surfaces of the foot.

Flexibility

The shod foot must be able to flex or bend in walking just as it does when the foot is bare. The insole (and sole) must therefore permit bending at the normal fulcrum of the foot. Rigid insoles (and soles) interfere with the normal dynamics of the foot, causing fatigue, muscular imbalance, strain and stresses which often result in backaches and other symptoms.

Added to this factor of flexibility, is the need for the insole to conform to the shape of the foot. Feet are made up of flat and curved surfaces which cannot be duplicated exactly to match the contours of the foot.

Shaped Shoes

Attempts to shape the insole contour of the foot are not new. The Danish traesko, the Dutch klompen, are shaped to conform somewhat to the contours of the foot.

One nationally advertised shoe contains a thermosetting plastic insole which, after heating, becomes soft and conforms to the wearer's foot contours. This is done in the shoe store—the plastic setting in a few minutes. Several custom-made shoes are made from a cast, either on weight bearing or semi-weight bearing. This impression is then incorporated in the shoe.

The impression or cast is taken during the resting phase of the static foot. This static impression is then reproduced into a shoe, which is a true replica of the foot at the very moment the impression was made. However, no allowance is made for the changing shapes of the foot.

Changes of the Foot

The foot is a constantly changing organ. It changes its shape, size and contour depending on:

1. The time of day (the foot increases in size toward the later hours).
2. Temperature and humidity (climate).
3. Occupation (walking, standing, sitting, variable loads, etc.).
4. Menstruation (cyclic anasarca) and pregnancy.
5. Diseases affecting the lower extremities (cardiac, kidney, circulatory, etc.).

It is readily evident that any shoe or insole made to an accurate impression (cast, etc.) can only fit the foot if the foot were a completely static organ. Foot contour and foot shape would have to remain static. This is a physiological and also a logical impossibility. These methods had to fail (except in isolated cases when the foot can adopt the shape imposed on it by the shoe or insole) because they did not take into consideration the basic dynamic and physiological factors of the foot.

Static and Dynamic Forces

The forces acting on the foot are:

1. The body weight or forces of gravity. The mass or body weight exerts continuous downward force on the foot, pressing the foot against the ground. A material which absorbs this energy of downward force is desirable.

2. Compression on the foot during locomotion. During locomotion, the foot is under compression, the energy necessary to move the body is in direct relation to the amount of compression forces exerted on the foot. The structure of the foot itself absorbs a considerable portion of these forces through elongation, etc., but the insole of the shoe must do the major share of energy absorption.

3. Impact forces of the moving foot contacting the stationary planes of the ground. During locomotion, impact makes considerable demands on the energy reserve of the body.

These forces, both static and dynamic, act continuously on the foot. They consume large amounts of the daily energy produced by the body. The reduction of these forces, through energy and impact absorbing materials will considerably reduce the energy expended and thereby create comfort and lessen fatigue.

Ideal Walking Surface

The ideal walking surface, i.e., insole, must inherently conform to the changing contours and demands of the foot, yet this ability to accept the changing shapes of the foot should not be rapid. It should rather be slow and gradual because the foot changes slowly. Inadequate insoles are in most instances the direct cause of plantar calluses and other, often more serious, conditions. The dynamic damage (loss of muscular energy) caused by the insole and shoe is readily apparent.

Existing Materials

Insole materials range from leather, of varying quality, to foam rubber, plastics, cardboard, textiles and compositions of cork, etc.

Foam Rubber

Materials with inherent elasticity such as foam rubbers are widely used. Their use is often justified by the catchword comfort. Their disadvantages, i.e., heat retention, absorption of the products of perspiration, chemical decomposition, are covered by a piece of sock lining which cannot hide the true facts too long. The foam rubbers decompose rapidly; they are hot and soon become odoriferous.

From a functional point of view, all foam rubbers interfere with the normal physiology of the foot. Foam rubbers, when compressed as in walking and standing, fight to return to their original shapes. Any deformation of the foam rubber caused by the process of standing or walking is counteracted by the inherent properties of the foam rubber to return to this original shape. Foam rubbers have perfect memory; they remember their original shapes. Therefore, the term fightback.

This fightback continuously interferes with the normal dynamics of the foot and leg muscles. The amount of muscular energy needed to counteract the fight of the foam rubber is substantial and exacts a tremendous toll of body energy. In terms of worker efficiency and productivity, it is a very costly luxury. Foam rubbers frequently are the villains in skin sensitizations and allergies. Their heat retention often increases the virulence of fungus infection of the foot.

Leather

Leather has been used as a material for footwear since the dawn of

mankind. Leather has many advantages, such as strength and stretch, flexibility and permeability. Leather is universally obtainable and can be worked with (during manufacture) ease.

As a material for uppers, leather certainly has most of the desirable features and practically no undesirable ones. As an insole material, however, it has several important disadvantages.

A leather insole is flat. Actually shoes with leather insoles are concave in order to fit over the convex wooden lasts. The anterior part of the foot, however, is just the opposite, causing it to be forced into this concave portion thereby aiding the breakdown or fall in of the anterior part of the foot.

The human foot, however, is made up of various concavities and convexities which, in a shoe with a flat leather insole, are forced to flatten. Considering foot dynamics, this causes undue strains and stresses on the plantar structures which respond by callus formation, etc. Furthermore, the energy needed to overcome this form of continuous insult while not as great as with the foam, is substantial enough to cause discomfort and fatigue.

Shoes with leather insoles do gradually attempt to conform to the foot. This is called the breaking in period. This process unfortunately takes so long that either the shoe is worn out by the time it is as comfortable as an old shoe, or the effects of this breaking in period can be seen most painfully in the podiatrist's office or on the beach. Cardboard insoles and similar materials are of such damaging impact on the foot that their use in shoe manufacture should be discouraged in the strongest possible terms.

Some manufacturers attempt to overcome this by placing metatarsal pads into the shoe either under or on top of the insole. This is doomed to failure because the position of the pad in the shoe rarely corresponds to the wearer's feet.

In McKay and Littleway construction, the stitchline around the insole causes a considerable number of irritating results; calluses, skin irritations, plantar neuroma, etc. The use of the process, especially for children's shoes should be altered to consider the effect on the foot.

The weltline or ridge, appearing on the insole of certain Goodyear Welt shoes, produces similar deleterious effects.

The New Insole

It became apparent that a material was needed which should incorporate a number of properties not available at present. In consultation with chemical and plastic engineers*, a number of specifications were arrived at and a new plastic was finally developed, flexible isocyanate–modified polyester.

Technically, this is a cellular plastic material, the result of the reaction of several chemical components. This action is enhanced by the addition of an activator. Substances are suspended in the plastic foam to add body and firmness. The addition of the inert substances is varied in accordance with use, and weight impact. The plastic can be made in molds or sheet form. Its physical properties are as follows:

Weight: It is lighter than natural or synthetic foam rubber.

Temperature variants: It withstands heat over 200 degrees F.

Cellstructure: Open.

Resistance to products of perspiration: Excellent.

Resistance to molds and fungi: Very good.

*Under the direction of Mr. John Maucieri.

Moisture absorbency: Low.

Aging: It resists aging from cold, heat, moisture and body perspiration.

The resiliency and elasticity of this plastic material, as well as its shock and impact absorbing properties, are controlled and varied in relation to the use to which it is intended; i.e., for heavy workshoes the impact absorption is greater than for lightweight ladies' shoes.

This material, named Living Fluid Insole because of its flowing and almost living ability to shape to the foot, was fabricated in ¼" to ⅜" thickness.

It has the following properties: It flows into each contour of the foot and does not immediately return to its original shape. It does not fight the foot. It deforms to the pressures applied upon it and yields with such deformation; then tends to return to its original shape in from twelve to twenty-four hours, thereby adjusting itself to the changes of the foot in size and load. (Compared to foam rubber which has 100% memory, this insole has less than 13% memory.) It shapes to the foot just as the wet sand does at the beach. It does not absorb perspiration, nor does it interfere with the temperature exchange of the skin. It provides adequate support to the foot and acts as a partial shock absorber. It encourages normal foot and toe function by aiding in the normal action of the toes. It will not wick. It has good insulation properties. It will not rot. It is fungus resistant. It can be sterilized in an autoclave. It actually breathes, since the air can freely flow through the material. It replaces the conventional insole. It can readily be used in Slip-lasted, Compo or Welt constructed shoes.

Field Test

A lightweight laced oxford, Slip-lasted construction, was used as a test shoe with this fluid, living insole. All supportive features such as long counters, etc., were omitted from the shoe.

These shoes were tried in cold climate, the desert, and under extreme working conditions, such as standing at a machine eight hours a day. Nurses, waitresses, housewives and women who do nothing at all, tried these shoes. Their subjective acceptance of the shoe has been most enthusiastic.

Another group of women, ranging in ages from 18 to 70, who suffered from such varied conditions as arthritis, plantar warts, excessive perspiration, bunions, hammertoes, varicose veins and arterial insufficiency, were fitted with these shoes and asked to wear them for two or three months. These women were not under active treatment, but were asked to report on the comfort of the shoes. With only two exceptions, all reported considerable comfort and lessening of fatigue, and reduction of symptoms.

Conclusion and Summary

A new plastic insole material, the result of a specific research program, is described. It has all the necessary physical properties to aid and assist the foot in the functions the foot must perform. It can adjust itself to the changes imposed on the foot by occupation, disease, pregnancy and any other demand modern man imposes on his foot. It does not create any problems to the manufacturer and its costs are about equal to any other quality insole material.

2453 So. La Cienega Blvd.

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(Continued on Page 545)

JOURNAL

OF THE

NATIONAL ASSOCIATION of CHIROPODISTS

PUBLISHED UNDER THE DIRECTION OF THE EXECUTIVE COUNCIL
BY THE NATIONAL ASSOCIATION OF CHIROPODISTS

3301 SIXTEENTH STREET, N. W.
WASHINGTON 10, D. C.

A. RUBIN, D.S.C., *Editor*

Address all communications intended for publication, matter relating to advertising, business or subscriptions to the Editor.

PRELIMINARY REPORT OF 1956 ANNUAL MEETING

PROBABLY the most significant event of this meeting was the adoption by the House of Delegates of Statements of Policy proposed by the Executive Council.

The Secretary announced that he had been advised by the Surgeon General of the Army's office that Chiropodists (Podiatrists) were being added to the list of commissioned medical officer specialists. Appropriate regulations and directives are presently being prepared. The number of officers that will be commissioned under this directive will not exceed nine.

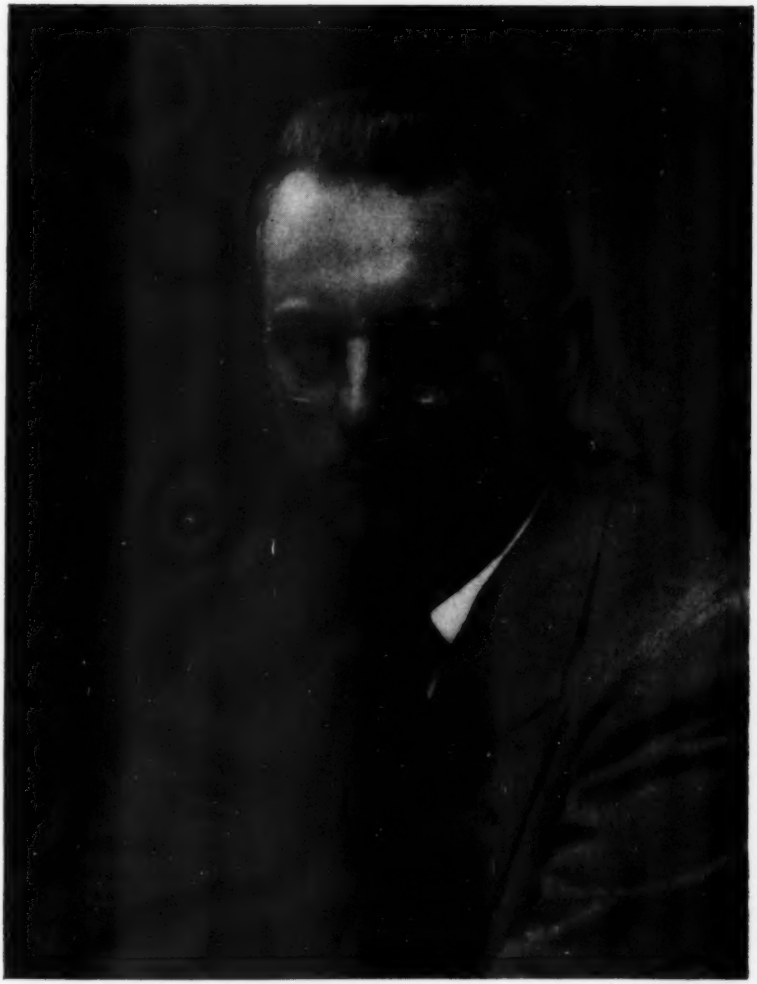
Dr. Felton O. Gamble, Tucson, Arizona, assumed the office of President from Dr. Ralph E. Fowler, Detroit, Michigan. Dr. Jonas C. Morris, Audubon, New Jersey, was elected President-Elect. Dr. George E. Guenzler, Freeport, Illinois, and Dr. Marvin W. Shapiro, Toledo, Ohio, were elected Vice Presidents. Dr. Harry I. Horowitz, Astoria, Long Island, New York, was re-elected and Dr. Charles R. Brantingham, Long Beach, California, elected to the Executive Council.

Drs. M. Gennis, Tulsa, Oklahoma, M. Speizman, Wilkes-Barre, Pennsylvania, and H. W. Weinerman, Brooklyn, New York, were re-elected to the Council on Education. Dr. C. Krausz, Philadelphia, Pennsylvania, and Dr. W. Dobbs, Fort Worth, Texas, were approved for appointment to the Council on Education. Drs. E. L. Tarara, Rochester, Minnesota, and Robert Shor, Los Angeles, California, were elected to the Board of Trustees, American Foot Health Foundation.

The announced award winners of the Wm. J. Stickel Annual Awards for Research in Chiropody are: first award, Dr. Phillip R. Brachman, Chicago, Ill.; second award, Dr. Marvin Steinberg, New York, N. Y.; third award, Dr. Raymond Locke, Englewood, N. J.; tied for the fourth award, Dr. Ralph Sansone, Hartford, Conn., and Dr. Harold M. Plaster (posthumously).

Our new Business Administrator, Mr. Franklin R. Fielding, was exceptionally well received in his first presentation to the House of Delegates.

A. Rubin, D.S.C.
Secretary



Fabian Bachrach

DR. FELTON O. GAMBLE

President
National Association of Chiropodists

CONGRESS CONSIDERS

On June 18 Congress passed what promises to be a very fruitful bill. It authorizes the Department of Health, Education and Welfare through the Surgeon General of Public Health to provide for a continuing survey to secure accurate and current statistical information on the amount, distribution and effects of illness and disability in the U.S. The Surgeon General is authorized to make by sampling or other appropriate means, surveys, and special studies of the population to determine the extent of illness and disability and related information such as: (a) the number, age, sex, ability to work of persons afflicted with chronic or other disease or injury or handicapping condition; (b) the type of disease or injury or handicapping condition of each person so afflicted; (c) length of time that each such person has been prevented from carrying on his occupation or activity; (d) amounts and types of services received for or because of such conditions and; (e) the economic and other impacts of such conditions; and to develop and test new or improved methods for obtaining current data on illness and disability.

The Surgeon General is further authorized, at appropriate intervals, to make available through publications and otherwise to any interested agencies, organizations, or groups or to the public, the results of surveys or studies.

To assist in carrying out the provisions, the Surgeon General is authorized and directed to cooperate and consult with the Department of Commerce and Labor and any other interested Federal Departments or agencies and with State health departments. It is contemplated the survey will be conducted largely by the Census Bureau.

There is an urgent need for a study of this character since it has been 20 years since a somewhat similar survey was made and therefore, at the present time, there is a serious lack of statistical information that is so necessary for the planning and execution of health programs by the States or the Federal Government or by local organizations.

The bill was recommended by the administration through a special message sent to the Congress by the President.

The secretary, here at the National Association headquarters, is writing to the Surgeon General asking that in making a program special attention be given to recording the incidence of disabilities and diseases of the feet of both children and adults. You may help by writing a similar request to the Surgeon General.

ANNUAL DUES

The fiscal year of the Association ends May 31st and the annual assessment is due and payable on June first. If strict adherence to this deadline was maintained, all members whose dues were not received in National Headquarters by June first would be delinquent. Members are urged to pay their dues immediately so that state secretaries may transmit to the secretary of the N.A.C.

CLINICALLY SPEAKING

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

HOSPITAL CHIROPODY*

EDWARD TORNOW, D.S.C.‡
Los Angeles, Calif.

The purpose of this paper is to present to the General Staff of this hospital the functions of the Chiropody Clinic in the outpatient department of the Cedars of Lebanon Hospital.

The Chiropody Clinic, although at present a subdivision of the Orthopedic Staff, offers the major part of its clinical services to the diabetic patient. This policy has been altered somewhat of late to extend its services to other departments upon referral by the respective departmental conferences.

During the year of 1954, the Chiropody Clinic treated 1,226 patients in a total of 672 hours with prevention and management of foot disorders by medical, mechanical and surgical means.

The Chiropody Clinic meets Tuesday and Friday mornings with an alternating seven-man staff. One chiropodist is assigned as a liaison officer to other clinics throughout the building in order to evaluate the specific chiropodical needs of their patients. Since this clinic is limited in physical size, interdepartment patients are screened where we feel that we can benefit the patient the most. Wherever possible, all diabetic patients are seen every three months, since statistically three to five percent of amputations result from poor prophylactic foot care of the diabetic.

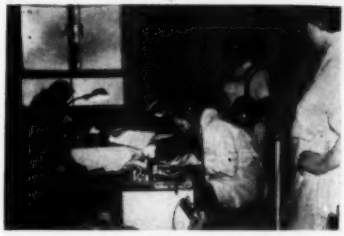


Fig. 1

Fig. 1 is a view of a portion of the Chiropody Clinic at work.

Fig. 2

Fig. 2 shows a diabetic with severe bunions being treated. This patient as a diabetic, and a poor risk for surgical intervention, is being prepared for latex shielding.

Fig. 3 shows a finished latex shield made over a previously prepared cast of the great toe. This is done by the use of Plaster of Paris splints that are used to take impressions of the area, dried and filled much in the same manner as the dentist prepares his positive for casting.

Liquid latex dippings of this mold with aperture pads for relief

*Read at Staff Conference, Lebanon Hall Auditorium, Cedars of Lebanon Hospital, December 19, 1955.

‡Chief of Staff, Outpatient Chiropody Clinic, Cedars of Lebanon Hospital, Los Angeles, California.

Fig. 3

of involved area suits this patient as a prophylactic measure.

Fig. 4, footgear of the patient is checked, advice given, and where indicated, proper corrections are made within the shoes.

Fig. 5 is a picture of our laboratory for shoe corrections, showing shoe correction for relief of a calcaneal spur.

Fig. 4

Fig. 5

Fig. 6 shows a hypertrophied nail, referred by the Dermatology Clinic, prior to treatment. Treatment in this case consists of periodically grinding down of nail plate.

Fig. 6

Fig. 7

Fig. 7 shows multiple mosaic warts of the distal areas of the toes under treatment.

Fig. 8

Fig. 8 shows same multiple mosaic wart case response to treatment.

Fig. 9

Fig. 9, severe contraction of the four lesser toes with cornification of the ends of the second, third, and fourth toes.

Fig. 10

Fig. 10 is end result of treatment to toes shown in Fig. 9. By proper buttress padding, a technique developed by our profession, this patient was made comfortable and excrescences at the ends of the toes disappeared.

Fig. 11

Fig. 11 shows surgical corrections of ingrown or inverted nails as done in our clinic, localized anesthesia 1% novocaine solution 3 cc, followed by initial incision to expose matrix.

Fig. 12

Fig. 12, removing proud flesh and offending matrix in toto.

Fig. 13

Fig. 13, removing exostosis, which in this particular case was the causative factor of matrix displacement.

Fig. 14

Fig. 14, nail border plastically corrected.

Fig. 15

Fig. 15, interrupted suture to close, for plastic linear healing.

Fig. 16, completed surgery before covering with sterile vaseline dressings. Each toe closed with two silk sutures.

Fig. 16

Fig. 17

Fig. 17, same patient two weeks later.

Time does not permit the showing of other methods of treatment, such as acrylic nail correction, and treatment of other conditions that are given to the chiropodical patient.

In closing, may I say that after a 9,000 mile tour last year, in which I visited such institutions as the Mayo Clinic, Rochester, Minn., Cook County Hospital, Chicago, Ill., Mercy Hospital, Chicago, Ill., New England Deaconess Hospital, Boston, Mass., Hospital of Joint Diseases, New York City, New York, and having spent time with Dr. Russell M. Wilder, and Dr. Eliott P. Joslin, I want to state at this time that we are proud of our affiliation with the Cedars of Lebanon Hospital, and that our Chiropodical Clinic and its interprofessional relationship with other departments is an outstanding achievement in hospital chiropody.

5135 Wilshire Blvd.

INJECTION THERAPY IN MORTON'S NEURALGIA

ERNEST W. WRIGHT, D.S.C.
Traverse City, Mich.

INTRACTABLE pain in the area between the heads of the 2nd, 3rd, 4th and 5th metatarsals caused by pressure involving an inflammation of the nerve can be satisfactorily injected with procaine hydrochloride 2% plain not at the trigger point where it is used most generally, but into the interspace just anterior to the bases of the heads involved.

The writer in injecting a considerable number of cases over a period of more than fifteen years has used this technic. The reason for injection at this site is that the nerve can be "hit" in about 95% of the cases where it is used. The patient will feel sharp pain for just a second when the nerve is reached. A needle, generally 25 gauge, is used and about 0.5 cc is injected. If the patient definitely has a neuralgia, relief will usually last from three to five days when another injection is administered. This will very frequently give relief of pain from five to seven days. The patient is advised to return when the pain recurs. Usually it takes three to four injections for the acute symptoms to subside more or less permanently. No other therapy is instituted while the patient is under this type of treatment.

In cases where there is no relief from pain, a neurofibroma is suspected. In cases of intermetatarsal bursitis, this form of therapy will not relieve the condition.

After the acute symptoms have subsided, rehabilitation therapy is instituted without the use of injections.

Summary

This procedure can be used as a D/D between a neuralgia and a neurofibroma. The freedom of excruciating pain is dramatic in patients who have an involvement of this nature and they should definitely be informed that only the inflammation of the nerve is being treated and not the causative factor. The amount of procaine used is very little and is not injected at the site of inflammation, where there already is a congestion of fluid in the tissues. The area injected by this method makes it quite easy to strike the nerve involved more often than if one were to inject between the metatarsal heads. In those cases where there is an involvement of more than one nerve both are injected.

123½ E. Front St.

DIFFERENTIATE ETIOLOGIES BEFORE TREATING THE BACK VIA THE FEET

M. H. WALKER, D.S.C.
Stamford, Conn.

METHODICAL examination of the patient with backache is required before the feet can be pin-pointed as the culprit. An accurate appraisal of the over-all condition combined with a general understanding of the pathology and involved mechanisms will insure proper diagnosis and consequent therapy.

The entire back, gluteal area, and the lower extremities must be scrutinized with the ranges of motion upon forward and lateral flexion, hyperextension, and rotation. The family physician can inform you as to the presence or absence of retroversion of the uterus, renal colic, prostatic hypertrophy, rectal fissures, constipation or any of the other vague but important causes of backache. The examining chiropodist should observe for pelvic tilt, muscle spasm or atrophy with a record kept as to the peripheral vascular picture. Neurological examination is conducted with the aid of pin and cotton, hot and cold test tubes, the signs of Babinski, Gordon, Abadie, and Romberg. Orthopedic tests of Leseque, Kernig and Fabere as well as anterior and posterior torsions and the lumbo-iliac and lumbosacral tests are included in the examination. Roentgenograms should be co-viewed with a competent physician, comprising anteroposterior, lateral and coned views of the lumbar spine and lumbosacral region.

To assure definite diagnosis of backache due to the feet the chiropodist should be aware of the most frequent causes, thus ruling them out. Pain in the low back with or without radiation into the legs frequently occurs after a specific injury. The pain is most severe at the onset of trauma and then slowly subsides. There is in this case a definite history of injury resulting in sprain. A ruptured intervertebral disk is frequently blamed for a disabling set of back symptoms, but actually this condition is the cause of less than 10% of back involvements. Examination usually reveals an absent or decreased knee or ankle jerk, hypesthesia in dermatone distribution to the lower extremity, and some atrophy of the involved leg. The signs of Kernig and Leseque are often demonstrated. The patient with degenerative joint disease such as osteoarthritis is frequently in his forties or fifties and is often obese. A soft tender mass over the sacro-iliac joint indicates an episacral lipoma. Conditions such as spina bifida, spondylolisthesis, sacralization of the transverse process of the fifth lumbar vertebra and other congenital malformations

are usually asymptomatic until the third decade of life when gradual onset of back pain related to muscular activity occurs. Diagnosis of back disorders owing to foot involvement is made by exclusion of the foregoing organic involvements. After you have satisfied yourself that there is no hidden cause of the back symptoms, treatment of a pair of pathological feet is definitely called for. Examination for the foregoing conditions may be made quickly ruling out two with one question or one observation. It is advisable to have the patient don a large white surgical gown (after disrobing) for examination, with your nurse or other third party present.

1521 Summer St.

CONGENITAL WEAKFOOT

OTTO N. SCHUSTER, D.S.C.
Chevy Chase, Md.

Congenital weakfoot has been described by many writers. All mention the pronated or valgus attitude under weight-bearing. Since weakfoot, congenital or acquired, is a disturbance of weight-bearing, a diagnosis cannot be made before the weight-bearing function has been acquired.

Whether weakfoot is inherited is questionable because of the innumerable variables. However, weakfoot cannot be inherited through a long line of ancestors who have acquired the condition by disease or wearing restricting or faulty footgear. Evidence points to the fact that acquired characters cannot be inherited.

The writer has had occasion to examine a large group of children afflicted with congenital weakfoot. It was noted that in many cases, the conventional devices, such as wedges, cookies, special shoes and foot braces, had little effect on the pronated or valgus attitude; the weakfoot attitude persisted under weight-bearing. In some instances marked pain developed in the calf muscles.

Careful examination disclosed that in many of these cases the passive motions of the feet were somewhat extreme, with the exception of flexion at the ankle (mid-tarsal joint locked). In the cases under study, flexion at the ankle only approached the right angle.

However, when the mid-tarsal joint was unlocked and the forefoot placed in valgus, flexion increased beyond the right angle. Actually, much of the flexion occurred at the mid-tarsal joint, accompanied by flattening of the longitudinal arch.

It would seem then, that some cases of congenital weakfoot are, in reality, undiagnosed cases of congenital talipes equinus, in which, because of the laxity of the tissues surrounding the mid-tarsal joint, permits the weakfoot attitude under weight-bearing.

Literally, the short calf muscles, existing in talipes equinus, pull the foot out of shape during weight-bearing. Mechanically, a heel, high enough to accommodate the equinus condition will relieve most of the weakfoot attitude. The addition of a weakfoot appliance will do the rest.

This method has been standard procedure, in the writer's practice, for many years, especially where the calf muscle cannot be lengthened.

In youngsters, with congenital weakfoot, based on a talipes equinus, all efforts should be made to lengthen the short calf muscle. It will be noted that when flexion at the ankle is increased beyond the right angle (mid-tarsal joint locked) all or most of the weakfoot attitude disappears. It is then only that

other corrective measures can be taken to encourage a better foot attitude during weight-bearing.

Conclusions

1. Many cases of congenital weakfoot are based on an existing talipes equinus.

2. The weakfoot attitude, in these cases, is caused by the resistance of the short calf muscles.

3. Treatment in these cases should be directed toward lengthening the calf muscles.

4. All or most of the valgus attitude (weakfoot attitude) disappears or becomes minimal when ankle flexion occurs beyond the right angle.

4605 Elm St.

PROBLEMS OF LOCOMOTION AND THEIR TREATMENT IN THE BRAIN INJURED CHILD AND ADULT

(Continued from Page 526)

The term "athetoid" is applied to a third group of cerebral palsy patients. The numbers in this group may be equal to those listed as spastics, but in general, the total involvements are not quite as severe.

As we have stated previously, these patients are affected primarily by involuntary, uncontrollable and incoordinate movements. These movements may take on any bizarre pattern and may be slow or rapid, sudden or jerky in character. Most of these patients learn how to walk despite this handicap but their problems multiply with increased activity. The mild athetoid gets along fairly well with all activities but the more severe athetoid experiences difficulty with all factors relating to foot care, from just lacing and tying his shoes to simple prophylactic care.

Many athetoids experience similar problems with maintaining balance that affect the cerebral palsy group in general and moderate to severe foot and leg deformities develop with time as malstructure follows malfunction. Talipes problems, knee problems, hip rotational problems and the lesser problems generally seen by the chiropodist can all be present and must be properly diagnosed and treated.

"Skate" therapy has been used with very good results in the treatment of young athetoid patients and within the past year I have extended the use of "skate" therapy for the care of young adult athetoid patients with striking results. In most instances even the older athetoid patients do not present true deformities or contractures. Theirs is primarily a positional deformity and the "skates," with their ability to restrain undesirable movements and direct the activity into new and more desirable neuromuscular patterns, apparently overcome this problem to a considerable degree. As far as our knowledge goes, no other therapy has been able to accomplish so much in so short a time for these patients and in most instances the adult problem was thought to be entirely hopeless.

The fourth classification we shall consider are the ataxics. The pure ataxic patient is not seen too often. As has been stated previously, the disturbance of balance and equilibrium are the outstanding symptoms found in this group. Their kinesthetic sense is greatly impaired. Other than that they have few of the other symptoms found in most cerebral palsy patients.

The ataxic patient has an unsteady gait and falls frequently if he is not extra careful. His main problem is to learn how to control his balance and be careful of the terrain over which he is walking. I have not had the opportunity to use any other special appliances on these patients other than balance inlays and they have been of some value.

Investigations Conducted and Planned

In February of 1955 I requested permission from the medical and clinical directors of the Mercy Hospital Rehabilitation Center to make a slow motion picture study of normal gaits and pathological gaits in young children, using the children attending our clinics as the subject material for this study. Approval was granted and I completed this pilot study in May of 1955.

My subjects were a normal five-year-old girl, a thirty-month-old quadriplegic spastic girl, a three-year-old athetoid girl, a nine-year-old hemiplegic boy and a seven-year-old ataxic boy. All of the cerebral palsy children could walk by themselves with varying degrees of stability and all were of sufficient intelligence to carry out most of the orders that were directed to them.

Since I required special slow motion camera equipment for this study, I was fortunate in receiving such assistance from the Illinois Institute of Technology. They supplied a technician and a Fastex camera, capable of taking moving pictures at any speed up to seven thousand frames a second. Our study was made at a speed of three hundred frames a second which was twenty times the speed of normal motion. The picture produced was slowed down to one-twentieth of the normal rate of motion.

This study gave us more than 800 feet of film depicting facts about normal and pathological gait that had not been observed before by any of the men in the medical specialties or allied medical fields, but the pilot effort that I was able to execute was only proof of the fact that a great deal more of this same investigation must be continued. Some of the facts learned by this study appear in the text of this thesis.

For many centuries medicine and its allied professions have been proud of the factual evidence they have been able to produce in all branches of practice. While the organized care of the cerebral palsy patient has a history of less than 25 years, there are very few facts that can be presented in the treatment of these patients where one could say with certainty "this method, if used according to all details listed, will bring results in 30 or 40 or 50 percent of the cases." Almost all the work that has been done is described with the appendage of "we think this is so" or "we believe this to be true." In other words, the entire program has been lacking in factual proof.

I hope that insofar as the foot and gait problem is concerned, that I have been able to bring some substantial evidence to bear concerning certain facts relating to treatment. When I first attended the clinics I was aware of the fact that all examinations of the lower extremity were made with the child in the sitting or in the prone position, regardless of the fact that the child could or could not bear some weight with or without help. Because of the fact that the feet are greatly responsible for a share of the proprioceptive sense and balance mechanism of the body, and also because the action of the muscles on weight bearing are greatly

altered in their actions as observed in the rest position—it is imperative that the examinations be carried out in both positions wherever feasible.

Weight bearing also sets up normal reflex arcs that are never found in the rest position and these reflexes also are of great importance in the understanding of the mechanism of locomotion. It is my belief that the most important of these is the Babinski reflex. While we know of it only as a diagnostic sign, it is far more than that. Actually, the Babinski response can be obtained by activating the motor reflex arc at any point on the plantar or dorsal area of the foot. Because of the fact that the cerebral patient is hypersensitive and has a great overflow of motor response going to some muscles, weight bearing alone may produce extra sensory stimulation that will be entirely different from the rest picture. By the same token it is also possible, by mechanical means, to inhibit some of these extra sensory factors and to stimulate others that may be more normal in scope.

In testing both spastic and athetoid children to determine whether or not I could elicit a certain reflex response at will by digital pressure, I applied pressure to the talo navicular articulation wherever I met with a peroneal spasm that held the foot in the range of marked abduction. This was the type of abduction that was associated with a stretch reflex and where the foot could be brought back to a normal alignment only after severe force was applied. In practically every instance, pressure at the talo navicular articulation set up a reflex response that released the spasm and allowed me to bring the foot into normal alignment with very little or no effort.

In applying this finding practically, I placed a high fulcrum into the shoes of these patients under the talo navicular articulation and achieved similar results on weight bearing. Then I designed balance inlays for these children carrying out the same principle with equally good results. In other words, the same reflex mechanism that produced the Babinski phenomenon was also used as a mechanical advantage in normal weight bearing and walking.

While the investigation and work that I have done to establish the validity of my hypothesis that reflexes in the feet are not just there to give us a diagnostic factor has been very limited, I am continuing this line of investigation with the addition of another hypothesis. It is my belief that all cerebral palsy children, and possibly other children with associated neurological disturbances, who cannot perform the initial functions of locomotion should receive the benefit of pressure therapy directed to the soles of the feet so as to activate or initiate the reflex response that is associated with direct weight bearing.

I hope to have more information to offer on this subject at a later date, but at the present time it does offer many interesting avenues for investigation for those who wish to avail themselves of what such an hypothesis may reveal.

And while I am on the subject of speculative problems associated with normal and abnormal gait, I would like to devote some space to another problem that has been of interest to me and one to which I have devoted a considerable amount of time and thought during the past two years. I refer to the definite relationship that exists between the development of all factors of active walking in the normal infant and child to that of the cere-

bral palsy child. My observations and study have lead me to the conclusion that all normal children follow the following pattern in learning how to walk:

1. Between four and seven months of age most children begin to develop reciprocal motion in both legs. This function becomes so well coordinated that if most children of seven months of age are held up in the erect position their little legs will move reciprocally as if they are ready to take off and walk without any effort.

2. From the seventh through the 12th month, most children develop the balance phase so essential for weight bearing and locomotion. They are able to raise themselves from the floor and by holding on they can achieve a good degree of balance.

3. From the twelfth to the twentieth month most children learn to walk without any further aid as follows:

   a. The first steps are hesitating and awkward with the child falling often.

   b. The stance is wide with the feet and legs widespread for greater stability.

   c. The knees are flexed.

   d. Most of the weight thrust is on the forefoot.

4. As the child continues to gain more confidence, the widespread stance disappears, the child falls less often, the knees no longer flex and the weight thrust comes down on the heel with the initiation of each step.

Now let us analyze the gait of the cerebral palsy child from the very beginning.

1. He may take from one to seven years or more to learn reciprocal leg motion.

2. He may require one to five years in addition before he gains sufficient balance to enable him to stand alone.

3. When some degree of walking actually becomes an accomplished fact, his gait will always have the following characteristics to some degree unless some drastic steps are taken to bring about desirable changes:

   a. His steps will remain hesitating and awkward and he will be subject to frequent falls.

   b. His stance will be widespread for greater stability.

   c. His knees will remain flexed in most instances.

   d. Most of the weight thrust will be on the forefoot and he will remain a toe heel walker.

   e. Partial ankylosis of the hip joints may bring about further complications in the gait problem.

It now becomes obvious how the cerebral pattern follows that of the normal child in everything except timing up to a certain point. That point is reached when the normal child is ready to iron out the rough spots in his gait from the 18th through the 24th month. The cerebral never irons out these rough spots and to a greater degree keeps them for a lifetime.

What can we as chiropodists do to help the cerebral iron out some of these rough spots in his attempt to walk more normally? We require more information about the development of the walking processes of the normal child. Such a study should be undertaken on an independent basis by a number of organizations and institutions but all should coordinate their efforts so that there will not be too much duplication of effort.

Because of the fact that "skate" therapy has resulted in the creation of a more normal pattern of walking by virtue of its restraining action, the creation of new reflex habit patterns approaching the nor-

mal, and its ability to bring the heel down from its elevated position, we should urge all those interested in this problem to include this therapy wherever it is indicated. Finally, we can use all of the modalities of physical therapy at our disposal to aid in the rehabilitation process so essential to the successful treatment of the cerebral palsy patient.

I have been deliberate in refraining from a discussion of surgery for the prevention or the correction of deformities in the cerebral palsy patient because most evidence now points to the fact that surgery has only a minor place in this entire program, if any at all. I would prefer, therefore, to let others offer a critical analysis of its value or lack of value.

Conclusion

The author has attempted to present a fairly comprehensive word picture of the cerebral palsy problem, particularly as it applies to those patients who have associated foot and gait difficulties. "Skate" therapy was stressed in this article because of the success that has attended the use of this treatment on a limited number of patients. It is the hope of the author that others who will have the patience to read these pages will take enough interest in cerebral palsy children to devote some of their time and energies to it. Those who do so will find a rich reward in the satisfaction of helping heal a crippled child.

25 E. Washington St.

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A NEW INSOLE MATERIAL FOR SHOES

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CHIROPODY AS A CAREER

"I THINK CHIROPODY AS A CAREER is a very helpful addition to our field of occupational information. I am placing it on our list which is sent to all counselors and hope that many will wish to order copies." Mary P. Corre, President, American Personnel and Guidance Association.

PHARMACEUTICAL PREPARATIONS FOR THE PROFESSION

Harry L. Hoffman, Ph.G., D.S.C.
Chairman, Council on Chiropodical Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This will be a regular monthly column and we invite questions, which we shall endeavor to answer, or obtain the answer.

Bacitracin
Antibiotic, Topical

Generic name: Bacitracin.

Description: A new antibiotic from cultures of Bacillus subtilis obtained from the drainage of a chronic osteomyelitis wound.

Action and Uses: Exerts a profound antibacterial action against many gram positive pathogens including the common streptococci and staphylococci; also destructive for certain gram negative organisms, the spirochete of syphillis and the Endamoeba histolytica; of low allergenicity on topical application. For use in pyogenic lesions, infected wounds, infectious conditions of the skin. Has been found of value in the treatment of mixed pyogenic infections and in those where one or more pyogens are resistant to penicillin.

Administration: Topically may be injected by local infiltration into the base of pyogenic lesions; for irrigation of infected wounds; as ointment in the treatment of many infectious conditions of the skin and of eye infections. Caution: *Never to be used parenterally for systemic use.*

Supplied: Ointment Bacitracin, 500 units per Gm (C.A.) in ½ oz. tubes by Abbott. Tubes: Ointment Bacitracin, 500 units per Gm, ½ oz., 1 oz., by Eli Lilly & Co. Baciguent ointment, 500 units per Gm in ½ oz. and 1 oz. tubes by Upjohn Co. Bactraycin ointment in 1 oz. and 2 oz. jars by Wallace. Also sterile powders of Bacitracin in vials containing 2,000, 10,000, and 5,000 units each of Bacitracin by Upjohn Co.

Meti-Derm

Composition: Meti-Derm cream contains in each gram 5 mg. prednisolone as the free alcohol in a water-washable base.

Description: Meti-Derm cream is a formulation of the free alcohol of prednisolone (Meticortelone) in a water soluble base for local administration in all skin disorders responsive to topical corticosteroid therapy. Meti-Derm cream exerts pronounced anti-inflammatory, anti-allergic and antipruritic action at the site of the lesion with minimal risk of systemic effects such as sodium retention, edema and weight gain.

Action and Uses: As an aid to conventional management, Meti-Derm cream will ameliorate the cutaneous manifestations of atopic dermatitis (allergic eczema, food eczema, infantile eczema, nummular eczema, eczematoid dermatitis, pruritis with lichenification, disseminated neurodermatitis), contact dermatitis due to plants and other substances.

Advantages: Topical application of Meti-Derm cream provides decrease in edema, inflammation, pruritis, erythema, and infiltration. Lesions fade and become flattened. Amelioration of pruritis results in decreased scratching, excoriation and associated infection.

Application: A small quantity of Meti-Derm cream should be rubbed gently on the affected areas three to four times daily. It is advisable to withhold treatment from infected areas.

How Supplied: Meti-Derm cream 0.5%, tube of 10 gms. Manufactured by Schering Corp., Bloomfield, N. J.

Source of Supply: Normal drug channels.

Typical Prescription:

Rx Meti-Derm Cream 10.0
(Schering)
Disp. tube #1
Sig: Rub a small amount of cream very gently into the affected area three times a day.

Tarcortin

Composition: 5% crude coal tar extract and 0.5% hydrocortisone in a nonstaining hydrophilic base.

Description: Tarcortin is a synergistic combination of tarbonis with 0.5% hydrocortisone. The synergistic combination of coal tar extract and hydrocortisone permits for lower dosage of steroid therapy, avoids rebound phenomenon, and is effective where tar alone, hydrocortisone alone, or other therapy fails.

Action and Uses: Tarcortin is effective in chronic and sub-acute dermatoses, particularly atopic eczema, nummular eczema, psoriasis, seborrheic dermatitis, dermatitis venenata, etc.

Advantages: Tarcortin has the distinct advantage of being more effective clinically than preparations containing more than twice the amount of steroid hormone. It is rapidly effective producing a clinical response during the first week of therapy. It is nonstaining and pleasant to use.

Application: Applied three or more times a day by gently massaging into the affected area.

How Supplied: 7 gm. and 1 oz. tubes. Manufactured by Reed & Carnrick, Jersey City, N. J.

Source of Supply: Normal drug channels.

Typical Prescription:

Rx Tarcortin 30.0
(Reed & Carnrick)
Disp. tube #1
Sig: Apply t.i.d., by gently massaging into the affected area.

Desitin Ointment

Composition: A smooth blend of crude Norwegian cod-liver oil, lanolin, petrolatum, zinc oxide and talcum.

Action and Uses: An effective soothing agent following the enucleation of corns and deep-seated tylomata, and to relieve the varied dermatologic symptoms accompanying inflamed nail grooves, inflamed heloma and tyloma, ulcers, granuloma pyogenicum, anidrosis, intertriginous dermatitis, neurodermatitis, the sub-acute stage of fungus infections, fissures, poison ivy, insect bites, sunburn, irritative dermatitides, inflamed bunion joints, chemical dermatitis and lacerated and denuded skin conditions.

Advantages: Desitin ointment has the distinct advantage of being conservative therapy that produces effective clinical response. It is pleasant to use. It lends itself as an excellent vehicle for antipruritic, fungicidal, antibiotic, antihistaminic and eczema preparations.

Application: Desitin ointment is applied directly to the area under treatment, but on denuded

areas it is best spread on a gauze pad and applied to make a comfortable dressing.

How Supplied: 1 ounce and 4 ounce tubes or pound jars. Manufactured by the Desitin Chemical Co., 70 Ship St., Providence 2, R. I.

Source of Supply: Normal drug channels.

Typical Prescription:

Rx Unguent. Desitin 30.0
(Desitin Chemical Co.)
Disp. tube #1.
Sig: Apply directly to part under treatment. Spread ointment on gauze before applying.

Clinistix (Ames Company)
A specific enzyme test for urine glucose

Description: Clinistix is an enzyme-impregnated test paper that produces a blue color when moistened with urine that contains glucose.

Action: Clinistix, to determine the presence or absence of glucose, utilizes a completely new principle in urine-sugar testing an enzyme system that is uniquely specific for glucose and extremely sensitive. Tests on several thousand urines have failed to reveal any substance causing a false positive. Clinistix can detect glucose concentrations of 0.1% or less.

Advantages: 1. Utmost simplicity and convenience; 2. Complete specificity; 3. Extreme sensitivity; 4. Qualitative accuracy.

Indications: Indispensable whenever rapid and/or frequently repeated qualitative determinations of urine glucose are required. Useful for differentiation of glucose from other urine sugars (lactose, pentose, fructose).

Directions: 1. Dip test end of Clinistix in urine and remove. (Or moisten with a drop of urine.) 2. Positive: Moistened end turns blue. Negative: No blue color develops. (Check both sides of strip.) When sugar is present, blue color normally appears in less than a minute, but occasionally may be delayed a minute or so, depending on nature of urine.

Important: Urine sugar tests based on enzymes may be affected by interfering substances such as ascorbic acid, and variations in the pH and temperature of the urine. This makes quantitation of glucose by enzymatic methods unreliable.

Supply: Available in packets of 30 Clinistix Reagent Strips in cartons of 12 No. 2830. Ames Company, Inc., Elkhart, Ind.

CORRECTION

In our column in June, we described Fungi-Treat (Dome Chemicals Co.). This preparation is known as Quatrasal.

TEST CONDUCTED ON WATERTIGHT SOX

THE RESULTS of recent tests on Dri-Foot and Dri-Forefoot have been announced.

Dri-Foot, a watertight, latex sock, that permits tub, shower, pool or surf bathing, was subjected to a number of two hour soaking tests, in a tub of water. In each instance, not alone did the strapping on the foot remain completely dry, but even the talcum powder inside the socks emerged bone dry.

Dri-Forefoot, designed for frontal foot protection only, was given the same tests and proved itself equally watertight.

STATE BOARD MEETINGS FOR EXAMINATION AND LICENSURE

Alabama
The Alabama Medical Board of Examiners. **Board Secretary:** Dr. Elizabeth P. Sealy, 34 South Perry Street, Montgomery, Ala.

Delaware
The State Board of Chiropody Examiners of Delaware. **Board Secretary:** Dr. Bertram H. Blum, 112 So. State St., Dover, Dela.

District of Columbia
The Board of Podiatry Examiners of the District of Columbia. **Board Secretary:** Dr. Richard A. Cole, 1835 K St., N. W., Washington 6, D. C.

Georgia
The Georgia State Board of Chiropody Examiners. **Board President:** Dr. Charles W. Beasley, Jr., 1205 First National Bank Bldg., Atlanta, Ga.

Idaho
The Idaho State Board of Chiropody Examiners. **Board Secretary:** Dr. Alma N. Miller, 301 Kane Bldg., Pocatello, Idaho.

Illinois
The Illinois Chiropody Examining Committee will meet in Chicago in June and December of each year. For this year, the dates are June 12-14 and December 19-21. Reciprocal applicants are interviewed and examinations for registration are held on the above dates. **Board Secretary:** Mr. Frederic B. Selcke, Superintendent of Registration, Department of Registration and Education, Springfield, Ill.

Massachusetts
The next board meeting of the Board of Registration in Chiropody-Podiatry will be held for reciprocity, conditionally, and examination, June and December, at the State House, Boston, Mass. **Board Secretary:** Charles H. Thorner, 1369 Hancock St., Quincy 69, Mass.

Mississippi
The Mississippi State Board of Health. **Board Secretary:** Dr. Felix J. Underwood, Old Capitol, Jackson, Miss.

Missouri
The next board meeting of the Missouri State Board of Chiropody will be held for reciprocity and examination on October 5, 1956, at the Hotel Governor, Jefferson City, Mo. **Board Secretary:** Dr. L. A. Hansen, 800 Professional Bldg., Kansas City, Mo.

New Hampshire
The New Hampshire Board of Registration in Chiropody. **Board Secretary:** John S. Wheeler, M.D., 107 State House, Concord, N. H.

North Carolina
The North Carolina State Board of Chiropody Examiners. **Board Secretary:** Dr. Charles Darby, P. O. Box 55, Statesville, N. C.

North Dakota
The next board meeting of the North Dakota Board of Registration in Chiropody will be held for reciprocity and examination on April 21, 1957, at 611 First Ave., No., Fargo, No. Dak. **Board Secretary:** Dr. E. B. Snuff, 611 First Ave., No., Fargo, No. Dak.

Oklahoma
The next board meeting of the Oklahoma State Board of Chiropody will be held for examination on September 22-23, 1956 at 1217 No. Walker St., Oklahoma City, Okla. **Board Secretary:** Dr. Warren D. Long, 1217 No. Walker St., Oklahoma City, Okla.

Tennessee
The Tennessee Board of Registration in Chiropody. **Board Secretary:** Dr, Arthur Richert, 3355 Poplar St., Memphis, Tenn.

Utah
The next board meeting of the Utah State Board of Chiropody Examiners will be held for examination in July 1957 at the State Capitol in Salt Lake City, Utah. **Board Secretary:** Dr. A. Bowden, First Security Bank Bldg., Provo, Utah.

West Virginia
The Medical Licensing Board of West Virginia. **Board Secretary:** N. H. Dyer, M.D., State Office Bldg., 1800 Washington St., Charleston, W. Va.

Wyoming
The Wyoming State Board of Registration in Chiropody. **Board Secretary:** Dr. Duane NeuSchultz, P. O. Box 1029, Torrington, Wyo.

N.A.C. WOMEN'S AUXILIARY

The President's Message

THE MOST NOBLE aspiration a person can achieve is the serving of his fellow man. If this can be accomplished to the best of his ability, then certainly he is the happiest of people. For what can be more worthwhile and produce more rewarding dividends in pure satisfaction? What can provide a greater means of accomplishment than the knowledge that one is helping to pave the way for others and making this world a better place in which to live?

This can be applied to organizations as well as individuals. It is true of the National Auxiliary—an organization which, since its inception in 1938, has strived to maintain a program dedicated to the progress of chiropody. By conscientiously adhering to this principle, working in closer liaison with the N.A.C. and its affiliated groups, we are gaining a broader knowledge of the scope of chiropody resulting in better public education.

Service – whether it be community relations projects, child welfare, hospital service, aiding with industrial foot health surveys and student procurement; participating in conventions, National Foot Health Week, these and more we were privileged to do again this year, effectively and wholeheartedly rendered.

A poor job can be done by anyone simply by using less effort and doing what has to be done only. It is the extras that count; the honest-to-goodness drive and effort; the eager willingness that very often spells the difference between mediocrity and success.

With the National Auxiliary rendering such service, public interest, appreciation and support will continue to follow, year after year resulting in greater strength and achievement for the profession. For, as we grow, so do our responsibilities and opportunities.

While achievements of the past are held in high regard, we are looking to the future, too, and this involves important points on the national level. These will be brought out at the National convention. We will continue to advocate measures which we believe are in the best interests of the profession, as well as the membership-at-large.

We are looking forward to the publication of the National Booklet "Life's Foundation Your Baby's Feet," which is in the process of printing as of this writing and will be ready for distribution shortly thereafter. Credit for this accomplishment is due Margaret Dobbs, past national president, the present Public Relations Chairman, and to the auxiliaries and divisions, all who contributed to this timely project. You are to be commended for your loyal support and complete cooperation.

GOOD COMPANY

CONSIDER what you have in the smallest chosen library. A company of the wisest and wittiest men that could be picked out of all civil countries, in a thousand years, have set in best order the results of their learning and wisdom. The men themselves were hid and inaccessible, solitary, impatient of interruption, fenced by etiquette; but the thought which they did not uncover to their bosom friend is here written out in transparent words to us, the strangers of another age. *Emerson.*

Recent reports from Vera Pearce, Membership Chairman, Thelma Cooper, Organization Chairman, and Thelma Parham, Secretary-Treasurer, indicate that we are fast reaching the 1,000 enrollment mark. We are happy to welcome the newly organized Louisiana Auxiliary, Washington State Auxiliary, plus a new auxiliary in Illinois. Each Auxiliary has shown an increase in membership both new and reactivated members. We hope in the near future to have the auxiliaries in New York, New England, New Jersey, Philadelphia, Pennsylvania, and other affiliated with the National Auxiliary.

There are three student body auxiliaries, California College of Chiropody, Temple University, and Illinois College of Chiropody and Foot Surgery. All are very enthusiastic and actively engaged in the promotion of the profession.

Our Visual Education program, under the direction of Margaret Goulson, is making excellent progress. Letters have been mailed to each president regarding the purchase and distribution of an excellent brochure printed by the National Association of Chiropodists entitled "Stepping Up to a Career," which is to be placed in high schools, libraries, junior colleges, and science groups. Movies and slides are also available. Chiropodists are urged and encouraged to speak before public groups. Each one of us can aid in this endeavor to publicize "Chiropody as a Career."

Public relation-wise our entire membership is to be commended for a job well done in promoting chiropody to the public. "Choose a Family Chiropodist" is apparently the password nowadays. If your home and office do not have the stamp for envelopes bearing the words, "Choose a Family Chiropodist," by all means it will behoove you to purchase them.

Take time to remember that chiropody is your husband's career. Help him to become more successful by showing keen interest; by offering encouragement and help. Make it your business to keep up with the progress in the profession. Read more about it, do not hesitate to ask questions and discuss it at your meetings. If you are your husband's office assistant, you are, indeed, lucky. Be a good listener and sit in on an association meeting now and then. You will find it stimulating and educational.

Better attendance at meetings can be stimulated and encouraged by promoting interesting as well as educational programs. Invite outstanding chiropodists to have panel discussions on various phases of the profession and have one moderate while showing films and slides. You will be doing yourself a favor and you can bet the chiropodists will appreciate your gesture.

It has come to my attention that auxiliary programs are inclined too often to dwell too much on social activities and less on achievement for the profession. We must realize that every organization has its basic reasons for existing, and ours is to further chiropody. It does not seem feasible, yet it is true in many cases that the social factor prevents many of our eligible women from becoming an organized group merely because so many of our chiropodists misinterpret or are not cognizant of the recognized services rendered by the National Auxiliary. Though the National Auxiliary is young in years, remember dentistry and medicine shared the same spot not too many years ago.

The importance of working in harmony with your Association cannot be stressed enough. Volunteer help on projects such as

industrial foot health surveys, student procurement, audio and visual education, etc. Suggestions and ideas are always welcome. Too many of us are apt to become overcritical rather than volunteer new ideas and aid.

Commend your fellow members for a job well done. Giving credit when it is due makes the future job even better. Above all, keep up your interest and enthusiasm.

How many ever stop to consider the fact that all of us can aid in establishing b e t t e r inter-professional relations. Recently, your president, being a registered nurse, took a six months leave of absence from her husband's office and joined the staff of a local hospital. With over 300 physicians and surgeons on the staff besides nurses, laboratory and X-ray technicians, a large majority of whom she comes in contact with during her eight-hour duty, it is surprising the percentage of professional men and women who claim ignorance regarding the vast scope of chiropody. This apparent lack of knowledge is evident throughout the states. Herein lies a fertile source for inter-professional education as to the scope of chiropody. Therefore, it is a wise chiropody wife who endeavors to keep up with a better knowledge of the profession. Thus, well informed along these lines she becomes chiropody's best public relations medium.

There is much to be accomplished, yet, with each of us united in effort and working towards a common goal, we can realize our achievements spontaneously.

May I hope to see more of you at the National Convention this year.

Miriam Shor, R. N.
President, Women's Auxiliary
National Association
of Chiropodists

ORGANIZATION NEWS

GEORGIA

AT THE ANNUAL MEETING of the Georgia Association of Chiropodists held in Augusta, at the Bon-Air Hotel on June 22-24, 1956, the following were installed as officers of the association:

President, Dr. Morton Wittenberg
President-elect, Dr. C. J. Pompei
Secretary-Treasurer, Dr. E. W. McGlamry
N.A.C. Delegate, Dr. Raymond J. Noonan

The scientific session included speakers from the Medical College of Georgia and a half day observation in the Crippled Children's Clinic. Chiropodists lecturing were Dr. Morton Wittenberg and Dr. Ernest Godwin.

The business sessions was comprised of committee reports and making final plans for the Region Ten meeting to be held in Atlanta, October 12-14, 1956.

Dr. Ray Noonan, our N.A.C. delegate, was instructed to vote for the change from "chiropodist" to "podiatrist." The Georgia Association of Chiropodists feels that this would be a great asset to the profession.

MASSACHUSETTS

DR. N. J. ROSSELLI, Chief of Podiatry, New England Medical Center, Boston, has been recently appointed to the Board of Health in Somerville, Mass.

NORTH CAROLINA

THE NORTH CAROLINA Chiropody Association held their annual meeting in Raleigh, June 25-26, 1956, at the Sir Walter Hotel. Dr. Paul Lyon, president, presided over the meeting. The following officers were elected for the ensuing year:

ANNOUNCING

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ANNUAL AWARDS FOR RESEARCH IN SHOE THERAPY

$1000.00 Annual Grants-In-Aid Awards To Be Divided Between Two Accredited Colleges of Chiropody and Their Shoe Therapy Directors

AWARDS FOR RESEARCH PAPER ON THE PRACTICAL APPLICATION OF SHOES TO FOOT PROBLEMS BY A MEMBER OF THE NATIONAL ASSOCIATION OF CHIROPODISTS

$300.00—First Award

$200.00—Second Award

RESEARCH PAPERS MUST BE SENT TO THE SECRETARY, NATIONAL ASSOCIATION OF CHIROPODISTS BY APRIL 15, 1957, TO BE JUDGED IN THIS YEAR'S CONTEST

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President, Dr. Basil Tucker
Vice President, Dr. Charles Cooper
Secretary-Treasurer, Dr. Donald Cameron
N.A.C. Delegate, Dr. James Davis
N.A.C. Alternate, Dr. C. Cutrell
Board Member, Dr. Charles Darby (3 years)

Dr. M. Moskow of Washington, D. C., was the lecturer for the scientific conclave.

The Society voted to have a public relations firm of Winston-Salem promote chiropody in our State. It was also voted to have a mid-winter scientific meeting each year.

PENNSYLVANIA

Northwestern Division

THE NORTHWESTERN Division of the Chiropody Society of Pennsylvania held a regular meeting on June 17, 1956, at the Brodhead Hotel in Beaver Falls, Pa.

Dr. H. H. Di Piero of Youngs-

POSTERIOR ACHILLO-BURSITIS

A deformity which can be demonstrated in many women who wear high heel shoes. Chronic or acute symptoms can be removed almost immediately with a LATEX appliance. In approximately 80% of these cases not only relief is acquired, but absolute absorption of the burso takes place.

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town, Ohio, was the scientific speaker. His topic of discussion was "Podopediatrics."

WYOMING

THE STATE Board of Registration in Chiropody met in Cheyenne on June 16, 1956. The newly elected members are: Dr. E. O. King, President; Dr. Herbert C. Fair, Vice President; Dr. Duane NeuSchultz, Secretary-Treasurer. No candidates appeared for the examination.

EXTENSION COURSE IN CLINICAL MEDICINE

THE ALBERTA CHIROPODY ASSOCIATION has arranged with the Department of Extension, University of Alberta, for its third annual short course in clinical medicine for chiropodists. This will be held at St. Stephen's College, Edmonton, October 1-2, 1956.

This course is open to all practicing chiropodists in Alberta.

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Subject topics to be covered are: "Mycology of the Feet"; "Treatment of Ringworm Infection of the Feet"; "Physiology of Muscle Tissue"; "Drugs Affecting Muscular Function"; "Chiropodical Roentgenology"; "Indications for Surgical Reconstruction of Foot Deformity."

"Oh come now Miss Popejoy — Relax!"

INDUSTRIAL HEALTH EXAM INCORPORATES PODIATRY SECTION

THE LONG ISLAND INSTITUTE OF HEALTH, in their diagnostic screening for preventive medicine in industrial health, has incorporated a section on the foot. The form lists a place for the family podiatrist as well as the family physician and dentist. One section of the examination form is devoted to preventive podiatry.

N.A.C.S — NEW YORK

THE NEWLY ELECTED OFFICERS of the National Association of Chiropody Students of the New York College of Podiatry for the year 1956-57 are as follows: President, Harvey Tilles; Vice President, Ernest Goldsmith; Secretary, Howard Werter; Treasurer, Robert E. Weinstock.

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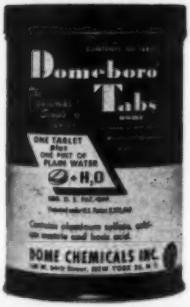

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STATE SOCIETY SETS UP LONG-TERM GOALS

AT THE ANNUAL MEETING of the House of Delegates, the Podiatry Society of the State of New York held in the Laurels Country Club, Monticello, in July, a series of comprehensive proposals presented by Dr. Irving Marks, First Vice President, Dr. Milton Werbel, Chairman of the Long Term Goals Committee, and Mr. Gilbert Hollander, Executive Secretary of the Podiatry Society.

Dr. Marks, along with Dr. Benjamin Mullens, State Public Information Chairman, led off with an evaluation of the importance of the examination with school children in relation to the legislative and public information program of the profession. In addition, he asked for the following program to be implemented and put into effect immediately: (1) A compulsory, not permissive, corporate health law that included podiatry; (2) Uniformity in fee in compensation treatment, and not the inequity that presently exists; (3) Compulsory annual foot health examination in schools; (4) A Casting Bill allowing only podiatrists and physicians to take plaster casts of patients' feet, or to use techniques for casting sandals, or other therapeutic appliances; (5) A law preventing the practice of podiatry in stores, beauty parlors, etc.; (6) Protection of the profession's scope of practice.

Dr. Werbel, in visualizing the long-term program of the Society, stated that the following must be the ultimate goal of the profession if we are to integrate foot care by the podiatrist into every phase of the health community.

Goals in Relation to the Public are: (1) School foot health clinics to become a continuing program of the profession in cooperation

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with local health agencies, Parent-Teacher Associations, and education authorities. The results of these studies to be made part of a suggested program of prophylactic foot care for prevention and reduction of foot disabilities in children; (2) Articles on foot care based on the above studies to be prepared and distributed to lay and professional publications; (3) Establishment of a non-profit organization with private and professional endowments to promote better foot health and to take a more active part in the profession's industrial foot health program.

Goals in Relation to Other Professions are: (1) To bring about a better understanding of podiatry's role in the healing arts within the other allied professions such as medicine, dentistry, nursing, etc.; (2) To improve the status of podiatrists at present on hospital staffs,

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originator of foot balance inlays is directed
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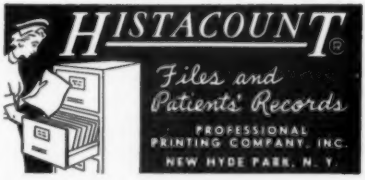
to create additional staff appointments for podiatrists in public and private hospitals, and to place podiatrists on a salaried basis in Geriatric, Welfare, and any other public and privately endowed institutions.

Goals to further scientific achievement would include stimulation of research through award and a complete program for the education of practitioners in the latest scientific advances in foot care.

Goals for the economic improvement of the profession would include the placing of podiatrists in all health plans and the use of podiatry service in compensation and industrial practice.

Mr. Hollander presented sketches and plans for a traveling exhibit on the role of the podiatrist in foot health which will be used in county fairs, expositions and similar shows throughout the state. Mr. Hollander estimated that the exhibit would be seen by 22 million people annually and would provide a tremendous force in bringing the message of foot health and prophylactic foot care to the public.

Copies of these reports, as long as they are available, may be obtained by state officials and other interested key practitioners throughout the country by writing to Mr. Gilbert Hollander, Executive Secretary, Podiatry Society of the State of New York, 353 West 57th Street, New York 19, N. Y.



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CHIROPODISTS PARTICIPATE IN JUBILEE MARATHON

FOR THE FIRST TIME, the Annual Jubilee Marathon held in Portsmouth, N. H., June 30th, received their foot care and check-up by a staff of chiropodists provided by the New Hampshire Chiropody Association.

The services rendered were so appreciated that it may become a regular feature of the yearly run. It left many favorable impressions, both for the State of New Hampshire and the chiropody practitioners. The introduction of continued treatment beyond the "on-the-spot" care was something new to the runners and their response to this idea was well worth our efforts.

The New Hampshire Chiropody Association hopes that any practitioner receiving this request for reasonable care will respond with honoring his letter of courtesy-cooperation given out by our Association. This was a fully sanctioned amateur race and, of course, participants run for the "good of the sport."

!!!

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California College of Chiropody
1770 Eddy Street
San Francisco, Calif.

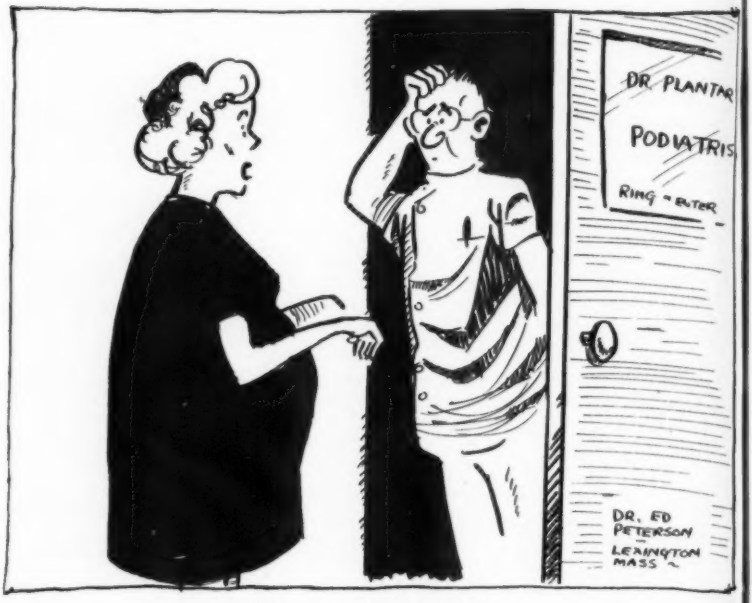
Chicago College of Chiropody
1422 W. Monroe Street
Chicago, Ill.

Illinois College of Chiropody and Foot Surgery
1327 North Clark Street
Chicago, Ill.

New York College of Podiatry
53 East 124th Street
New York, N. Y.

Ohio College of Chiropody
2057 Cornell Road
Cleveland, Ohio

Temple University, School of Chiropody
1810 Spring Garden Street
Philadelphia, Pa.



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We strongly recommend it for those suffering from Arthritis, Circulatory or Diabetic conditions. Also for bony, rigid and sensitive feet as well as for Verruca, Ulcers and Scar Tissues. It also is made in an inlay type without crest.

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MOOD ELEVATORS

Contributions to this column are more than welcome. In fact it depends upon them.

A.O.P.

In a football game between North Carolina and Notre Dame one of the Tarheel boys complained that his opponent was "jest a-chewin' and a-chewin' me. Four times he has just chewed me up."

"Well," said the manager, "hereafter we'll only play them on Friday."

The Italian fruit vender was hollering, "Murder!" at the top of his lungs. A crowd collected and demanded to know what it was all about.

"I yell banana," he said "and nobody come. So I yell murder. How many banana you want?"

The driver of a carload of party-goers winced as one of the singers of *Sweet Adeline* hit several sour notes.

"Here, Joe," he said disgustedly, "*you* drive. You're too drunk to sing."

Overheard

L. S. Wyatt was in a cafe on Route 29 when a stranger came in and asked, "How far is it to Front Royal from here?"

"Gosh, I don't know how far it is from here," replied a man seated near the door. "But I live 10 miles down the road, and from my house it's 50 miles."

Washington Post and Times-Herald

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Small (2-5)
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ANCIENT GREEKS wore two types of shoes: one had drawings of their enemies on the soles of the shoes, so the wearer could step on his enemies constantly. The other had soles so constructed that the shoes produced a musical tone when used for walking or running.

In Aztec writing, footprints were used to indicate roads; in Egyptian hieroglyphics, the foot and leg indicated the letter "B."

KUSH-N-ARCH

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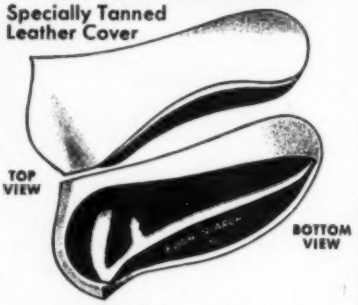

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CONVENTION DATES

1956

CANADIAN ASSOCIATION OF CHIROPODISTS
Saskatoon, Sask., Canada
August 28-31, 1956
University of Saskatchewan

WYOMING ASSOCIATION OF CHIROPODISTS
Casper, Wyo.
October 5-6, 1956
I.O.O.F. Building

REGION EIGHT
Washington, D. C.
October 5-7, 1956
Hotel Statler

REGION ONE
Swampscott, Mass.
October 12-14, 1956
New Ocean House

1957

REGION SIX
St. Louis, Mo.
May 3-5, 1957
Hotel Statler

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N.A.C.

MEETINGS

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WANTED—CALIFORNIA: Experienced and licensed 1955 graduate desires associateship with chiropodist in southern California. Will consider purchase of practice. Will also take offices during vacation or illness. William O. Nankee, D.S.C., 259 N. Euclid Ave., Pasadena 1, Calif. Phone: SYcamore 6-8760.

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